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RESEARCH BRIEF

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Legal Threats to Autonomy, Choice, and Informed Consent in Labor and Childbirth

How the law makes pregnant and birthing people vulnerable to mistreatment and unconsented practices

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Executive Summary

The principles of autonomy, informed consent, and choice are well-established in healthcare. Nonetheless, the application of these guidelines to pregnant patients varies across jurisdictions. The difference in treatment of pregnant patients arises from a variety of reasons, including gender stereotypes, patriarchal medical practices, and overworked and overburdened healthcare systems. The mistreatment of pregnant people in healthcare has continued to rise as a concern in international and national spaces as facility-based childbirth rates increase. Whether legal frameworks enhance or limit pregnant patients' rights, particularly those of autonomy, informed consent, and choice during labor and childbirth, is not widely addressed in the international human rights space. This research seeks to explore how legal frameworks are set up to protect pregnant patients, or how they inhibit pregnant people from being seen as fully autonomous patients, worthy of the same legal protections as non-pregnant patients. This report looks at the laws and policies in international human rights law, as well as twelve key countries, identifying key legislation, jurisprudence, and policies that advance or restrict pregnant people's rights to autonomy, informed consent, and choice.

Five main factors were identified as limiting to pregnant people's rights to autonomy, informed consent, and choice:

1. **Overly broad emergency exceptions to informed consent:** Legal frameworks allow ambiguous exceptions to informed consent in cases of emergency, which may be disproportionately relied on during labor and childbirth when perceptions of risk or emergency are heightened.

2. **Legal recognition of superseding fetal protections:** Some jurisdictions prioritize protecting fetal wellbeing over the pregnant person's choice and autonomy, allowing non-consensual treatment if the pregnant patient's denial of care would pose a risk to the fetus's health or life.

3. **Permitting the withholding of information during labor and delivery:** Certain countries recognize therapeutic privilege, which allows healthcare staff to refrain from sharing certain information that may harm the patient's physical, mental, or emotional wellbeing.

4. **Lack of protection to the right to choose the circumstances surrounding birth:** Legal frameworks fail to recognize or protect the rights of pregnant patients to choose where, with whom, and in what manner to give birth.

5. **Limited remedies and lack of system-wide change:** Countries that do impose punishment for violations of pregnant people's rights focus on individual accountability, rather than addressing the systemic root of these violations.

In turn, this report emphasizes seven recommendations that strengthen the protection of pregnant patients' rights in legal frameworks:

Rely on a human-rights based approach to maternal health legislation and policies.	1
Ensure legal recognition of specific maternal health rights in labor and delivery, including the right to informed consent and refusal, the right to make decisions that may contradict medical advice, and the right to choose the circumstances around their birth.	2
Clearly define when an emergency exception applies to informed consent, particularly in labor and delivery.	3
Protect the right to refuse treatment, even when pregnant and when the refusal may contradict presumed fetal interests.	4
Protect against coercive treatments and the withholding of information in maternal healthcare.	5
Reject criminalization and punitive approaches without addressing necessary systemic changes.	6
Implement training of healthcare staff on pregnant patients' rights and data gathering practices.	7

Introduction

Labor and childbirth are among the most fundamental ways women and people capable of gestating[1] engage with healthcare systems. Yet, paradoxically, childbirth remains an area of healthcare where legal protections for autonomy, informed consent, and refusals of care are notably weak. Despite broad recognition of these rights in medical ethics and law, many pregnant people are not treated as fully autonomous subjects, facing routine coercion, nonconsensual medical interventions, and restrictions on decision-making during labor and birth. Certain populations are more likely to experience these forms of mistreatment because of marginalization, exclusion, or stigmatization, including people from minority racial, ethnic, and religious groups, socioeconomically disadvantaged populations, people living with disabilities, adolescents, unmarried people, and those living with HIV. This mistreatment has direct and adverse consequences for both pregnant people and their children.

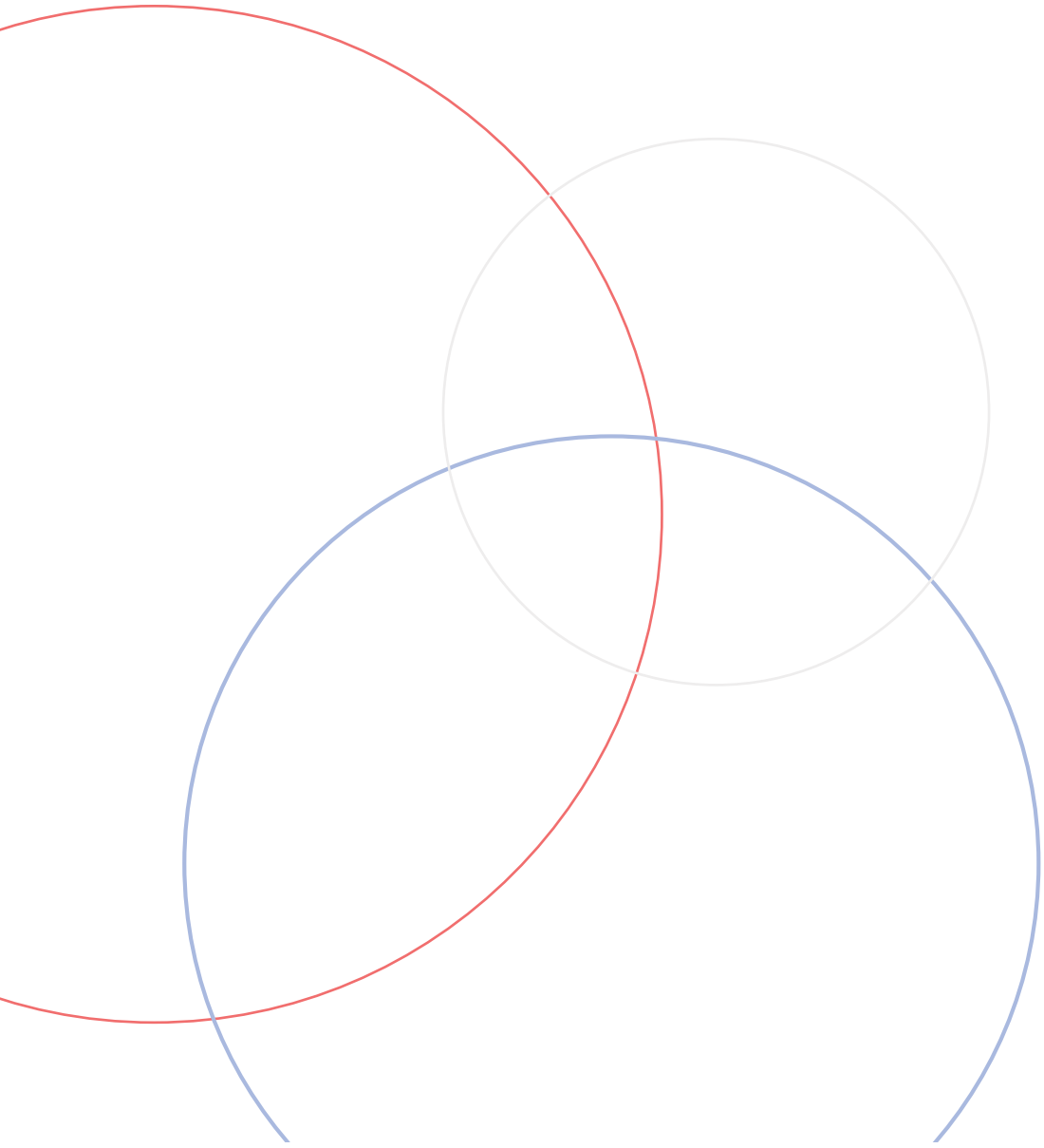
This research brief seeks to deepen understanding of how national legal frameworks may enable, neglect, or undermine pregnant people's autonomy and informed consent during labor and childbirth. Although there is growing research and commentary on the human rights violations and implications of mistreatment during facility-based childbirth, legal research and advocacy focused on autonomy, informed consent, and refusal of care are scarce. This research tries to address this gap and provide evidence on how laws either explicitly restrict autonomy or fail to offer adequate protections for pregnant people against unconsented care and loss of autonomy. It aims to elucidate these questions by presenting an analysis of caselaw by international and regional human rights bodies along with a review of laws and regulations across twelve countries—Bangladesh, Brazil, Colombia, India, Kenya, Malawi, Mexico, Pakistan, Romania, Spain, Uganda, and the United States. It identifies key gaps, challenges, and good practices within each legal framework. In addition, the study examines supporting systems such as redress mechanisms, maternal health policies, and guidelines directed at healthcare providers.

While countries across the world have made important efforts to understand, prevent, and eliminate mistreatment of pregnant people during childbirth, this research underscores that the critical legal issues contributing to mistreatment have been overlooked. At the root of the maternal morbidity, mortality and mistreatment crisis are legal and professional frameworks that do not recognize pregnant people as independent agents during pregnancy and childbirth and curtail access to patient-centered models of care.

> **Maternal health is the only field in medicine and law in which informed consent can be overridden, and patients can be forced to submit to compulsory treatment against their will.**

1 The Center for Reproductive Rights recognizes that birthing people of all genders are entitled to the right to autonomy, choice, and informed consent in pregnancy. Where possible, the authors will use gender-neutral language. Gendered language will be used when explicitly referenced as such in laws, policies, guidelines, or other relevant sources.

When we think about a lack of agency and autonomy in relation to reproductive rights, we think about abortion and how legal systems around the world interfere, restrict, and create obstacles to a person's decision to get an abortion. However, pregnant people also overwhelmingly lack autonomy and agency during pregnancy, and particularly during labor and delivery.



Methods

This research employed a four-step approach to investigate legal protections for autonomy, informed consent, and refusals of treatment during labor and childbirth. It began with a targeted literature review to map existing research on respectful maternity care, mistreatment in childbirth, and the role of autonomy in medical practice. Drawing from databases such as JSTOR, PubMed, Google Scholar, and HeinOnline, this review provided a foundational understanding of the current knowledge landscape and informed the development of our research questions.

Next, we conducted a legal mapping of twelve countries, analyzing publicly available legal documents, including constitutional provisions, laws, regulations, ethical codes, public policies, and judicial decisions that address decision-making rights in childbirth. This was followed by a comparative cross-country analysis to identify legal patterns, divergences, and gaps in alignment with human rights norms. Lastly, we engaged in a forward-looking process to identify core challenges and develop recommendations aimed at strengthening legal protections for autonomy and informed consent during labor and childbirth.

The research benefited from the expertise and perspectives of legal, human rights, and public health experts who participated in a consultation held in Geneva on February 26-27, 2025. Their contributions were instrumental in shaping the findings and recommendations presented in this brief.

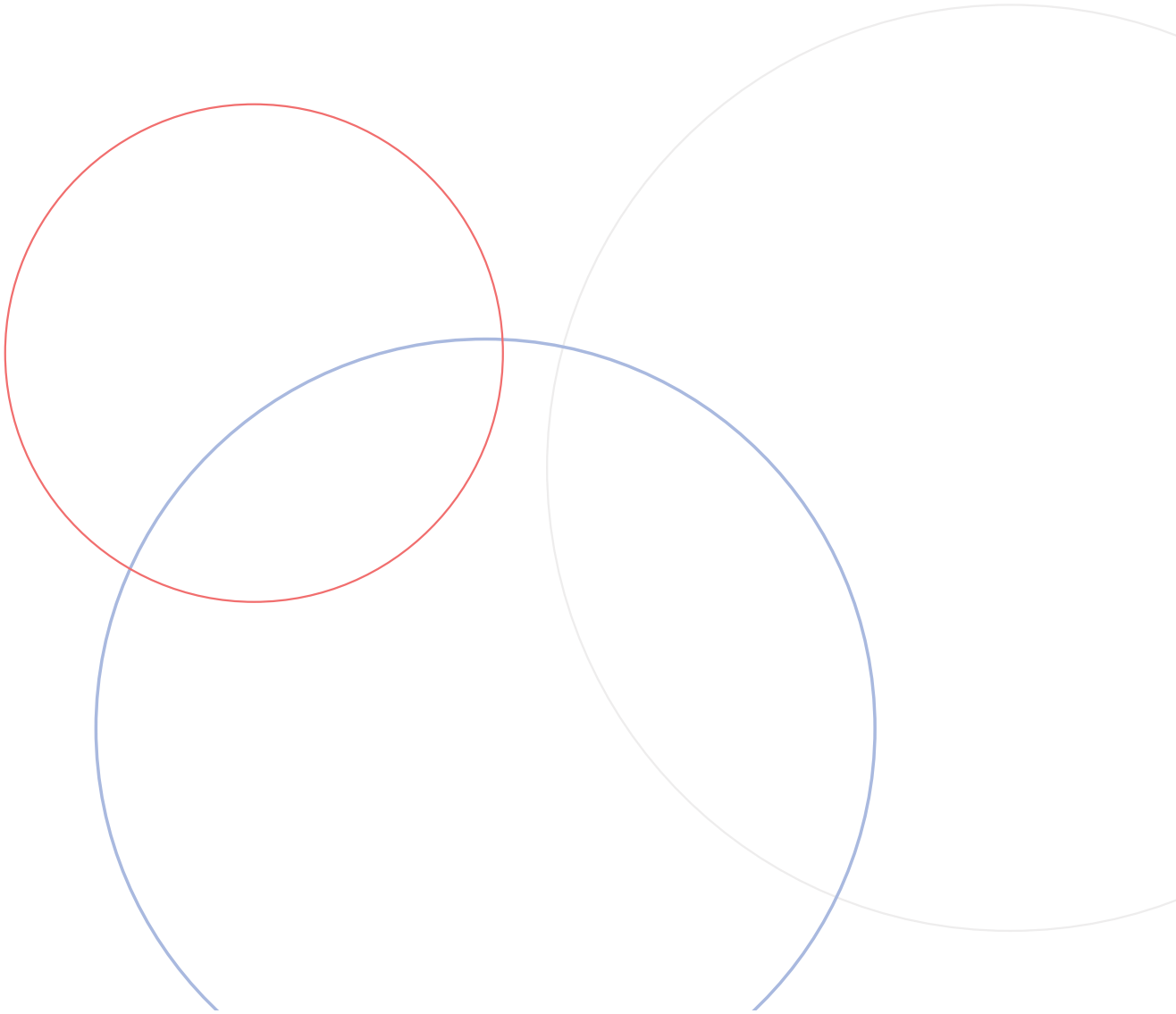
LIMITATIONS

The study is primarily based on desk research across twelve countries, and while the selection reflects regional and legal diversity, it is not exhaustive. Access to primary legal sources, particularly court decisions and subnational regulations, was uneven. In several jurisdictions, judgments related to childbirth, including medical malpractice and disciplinary rulings, were either unpublished or unavailable in searchable databases. These gaps may result in an underrepresentation of case law that affirms or challenges the rights to autonomy, informed consent, and refusals during labor and childbirth.

Finally, this study focuses on the legal experiences and protections of competent adult pregnant people. It does not explore in depth the additional and complex legal barriers faced by pregnant adolescents or people living with intellectual disabilities, whose capacity is often more heavily regulated or contested across legal systems. These populations face distinct and exacerbated forms of legal and medical disempowerment that merit separate, focused research.

Despite these limitations, this analysis offers insightful foundations for understanding how legal systems shape decision-making in childbirth and for identifying opportunities to strengthen legal protections in this critical area of healthcare.

This report is divided in four parts. Part I provides key concepts and definitions, as well as five key elements of a weak legal framework that does not advance the rights of pregnant patients. Part II outlines the current status of maternal health around the world, and international calls to address mistreatment in childbirth. Part III identifies how rights to autonomy, informed consent, and choice are referenced in international human rights systems, and details national legal frameworks that protect or restrict maternal health rights. The report concludes with seven recommendations to improve legal protections of pregnant people's rights to autonomy, informed consent, and choice.



PART 1

Definitions and Scope of Research

Key concepts and definitions

Autonomy, choice, informed consent, and refusals of care are foundational principles in both medical ethics and the law, as well as fundamental rights recognized under human rights norms and standards. This section provides working definitions used throughout this brief:

Bodily autonomy refers to the legal and ethical right to control one's body and health without coercion or interference from others.[2] At its core, autonomy affirms a person's agency – the recognition that individuals are active decision makers, not passive recipients of care or objects of medical intervention.[3]

Freedom of choice refers to a person's right and ability to select among choices of care, such as what treatment they receive, where they receive it, and by whom, and respecting those decisions in healthcare, regardless of the reason, values, or preferences. It is a subset of autonomy relating to a person's healthcare experience and care. Without meaningful options, choice is limited or illusory.

Informed consent is a process and a legal requirement that operationalizes autonomy and choice. It requires that any medical intervention (preventative, diagnostic, and therapeutic intervention or scientific experimentation) be performed only with the voluntary agreement of the patient, based on full disclosure of the risks, benefits, and alternatives.[4] Informed consent is not mere acceptance of a medical intervention or the signature on a written form, but an ongoing communicative process that respects autonomy and enables choice.[5]

Inherent to the right to informed consent is the **right to refuse treatment** or any recommended intervention, even if refusal will result in death or serious harm.[6] This is well-established across various legal and ethical norms.[7] Informed consent and refusal should be

2 United Nations Educational, Scientific, and Cultural Organization [UNESCO], Universal Declaration of Bioethics and Human Rights, Art. 5 (2005); Committee on Economic, Social and Cultural Rights [CESCR], *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)* (2000), U.N. Doc. E/C.12/2000/4, para. 8, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf [hereinafter, CESCR Committee, Gen. Com. No. 14].

3 *See, e.g.,* CESCR Committee Gen. Com. No. 14, para. 8 (describing the freedom associated with the right to health to include "the right to control one's health and body, including sexual and reproductive freedom). *See also* Convention on the Rights of People with Disabilities, Art. 3(a) (2007) (establishing the right to individual autonomy, including the freedom to make one's own choices and independence of persons"); *and* Inter-American Court of Human Rights [IACtHR], *Case of I.V. v. Bolivia* (2016), para. 161 (determining the patient is "the principal actor in terms of making decisions about their body and health…the patient is free to opt for alternatives that the doctors could consider contrary to their advice, thus being the clearest expression of respect for autonomy in the medical field").

4 World Medical Association, *International Code of Medical Ethics* (Apr. 14, 2023), https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/.

5 General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2009), U.N. Doc. A/64/272, para. 9, https://documents.un.org/doc/undoc/gen/n09/450/87/pdf/n0945087.pdf.

6 This is established in art. 4 of the European Charter of Patients' Rights, which provides that "[a] patient has the right to refuse a treatment or a medical intervention and to change his or her mind during the treatment, refusing its continuation." See European Charter of Patients' Rights (2002), Art. 4, https://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf.

7 Lane v. Candura, 376 N.E.2d 1232 (1978). *See also* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990); U.K. General Medical Council, *Factsheet: Key Legislation and Case Law Relating to Decision Making and Consent,* 6-7, https://www.gmc-uk.org/-/media/documents/factsheet---key-legislation-and-case-law-relating-to-decision-making-and-consent-84176182.pdf (last visited Jun. 2, 2025); Re B [2002] 2 Eng. Rep. 449 (U.K.); A Ward of Court, Re A [1995] IESC 1 (Ireland).

understood as a matter of choice, and it does not need to be based on medical considerations.[8] A patient may decide for their own reasons according to their own values and preferences.

Related to these principles is **personal dignity**, which in healthcare requires recognizing the person as worthy of respectful care and capable of making decisions about their own bodies in alignment with their life and health goals, values, and preferences.[9] Autonomy, choice, and informed consent/refusal allow a patient to be treated with dignity.

In the context of pregnancy and childbirth, the rights to autonomy, choice, and informed consent/refusal affirm the pregnant person's right to have decisional authority regarding what is safe, healthy, and in their and the newborn's best interests. This includes decisions around the manner and circumstances of childbirth, including the mode of delivery, pain relief methods, birth positions, the presence of companions, and the place of birth. These rights require that medical information be provided free from coercion and in a way that upholds self-determination and control. Treating the fetus as a separate rights-holder and overriding the pregnant person's refusal of recommended care constitutes a violation of dignity, autonomy, and informed consent in maternal healthcare.

BOX 1: Autonomy vs. "Participation" in Decision-Making

In many healthcare policy documents related to maternity care, there is a tendency to frame the right to autonomy of pregnant people in terms of "participation" or being "involved" in healthcare decisions related to their bodies and health, rather than being recognized as the primary and final decision-makers. While the language of involvement may appear positive on the surface, it reflects a limited, and ultimately paternalistic, conception of a patient's agency. Being merely "involved" in decision-making suggests that the healthcare provider retains ultimate authority while the patient is permitted to offer input. This implies a shared or secondary role, where the patient's preferences may be considered but can be overridden in the name of clinical judgment or institutional policy. It reduces autonomy to a consultative process rather than a legally enforceable right.

Bodily autonomy affirms the person as the sole authority over their healthcare choices, including the right to accept or refuse any proposed intervention. This is especially critical during pregnancy, labor, and childbirth, where the consequences of decision-making are immediate and deeply personal. True respect for autonomy requires more than participation; it demands recognition of the pregnant person as the final decision maker over their body and health – even when choices conflict from clinical recommendations.

8 *See* IACtHR, Case of I.V. v. Bolivia (2016), para. 161 (determining the patient is "the principal actor in terms of making decisions about their body and health…the patient is free to opt for alternatives that the doctors could consider contrary to their advice, thus being the clearest expression of respect for autonomy in the medical field"). See also General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2009), U.N. Doc. A/64/272, para. 28, https://documents.un.org/doc/undoc/gen/n09/450/87/pdf/n0945087.pdf.

9 CESCR Committee, Gen. Com. No. 22, para. 25. *See also* IACtHR, *Poblete Vilches and Others v. Chile* (2018), para. 170.

Characteristics of a Weak Legal Framework

The regulation of autonomy, choice, and informed consent during labor and childbirth intersects multiple and complex areas of law, including human rights, health law, medical liability, criminal law, consumer protection, and professional standards and regulation. These legal frameworks shape the conditions under which care is provided, consent is obtained, and accountability is pursued. A full review of this legal landscape is beyond the scope of this research. Rather, this study focuses on the following legal issues that directly impact the exercise of autonomy in labor and childbirth and identifies where legal strengthening may be most urgently needed.

1. Medical Necessity and Emergency Claims as Exceptions to Consent in Labor and Childbirth

In the context of maternity care, medical necessity claims or emergency exceptions are often used as justification to presume or override a pregnant person's preferences or consent and perform an intervention that is deemed necessary to prevent harm to the mother or the fetus. While in principle, medical necessity can serve a legitimate and important function, such as in life-threatening emergencies, it is often invoked broadly and ambiguously, especially during labor and childbirth. A lack of legal clarity of what constitutes a life-threatening emergency can lead healthcare professionals to reject the pregnant person's preferences, agency, and wellbeing to protect them against tort and medical negligence claims.[10]

2. The Right to Refuse Treatment and the Fetal Interest Override

A review of literature and comparative case law indicates that some legal systems still favor the survival of the fetus over the pregnant person's rights.[11] These systems may deny a pregnant person's choices on the manner, circumstances, and setting of giving birth, narrow standards for informed consent during childbirth, and treat injuries to the pregnant person as acceptable harms in the interest of the fetus.[12]

3. Withholding Information during Labor and Childbirth

Access to information is a prerequisite to informed consent, yet in some legal systems, the law may allow providers to withhold certain information (**therapeutic privilege**), particularly around options such as modes of delivery, pain relief, or the right to refuse treatment. Laws may also fail to impose clear legal duties on providers to disclose risks and alternative treatments.

4. The Right to Choose the Manner and Circumstances of Giving Birth

Laws relevant to healthcare or specifically maternity care may not include the rights of pregnant people to choose the manner and circumstances of giving birth. This includes choosing where and with whom they give birth, the use of pharmacological and non-

10 Developments in the Law, *The Legal Infrastructure of Childbirth, Chapter Three,* 134 Harv. L. Rev. 2209 (2021).

11 Elizabeth Kukura, Pregnancy Risk and Coerced Interventions After Dobbs, 76 SMU Law Review 105 (2023); Francisco Javier Matia Portilla, ¿Puede un órgano judicial acordar el ingreso hospitalario de una mujer embarazada sin oír a la afectada y al margen de sus competencias legales?, (STC 66/2022, de 22 de junio), Revista Española de Derecho Constitucional 128, 239-268 (2022).

12 Elizabeth Kukura, *Pregnancy Risk and Coerced Interventions After Dobbs,* 76 SMU Law Review 105 (2023).

pharmacological pain management, and postpartum care decisions for themselves and their newborn.

5. Legal Remedies for Systemic Change

States have various avenues to ensure accountability and remedy violations linked to mistreatment and nonconsensual care in maternal health. However, many focus on individual responsibility, such as imposing fines, revoking licenses, and jail time for health professionals in some cases. This approach can be unduly punitive and ineffective at achieving the system-wide change needed to protect all pregnant people's rights.

BOX 2: The impact of weak legal frameworks on healthcare providers

Misguided, outdated, vague, and discriminatory laws not only impair pregnant peoples' rights and access to quality and respectful maternity care, but they also have significant negative implications on the working conditions of healthcare professionals. Weak legal frameworks can force healthcare professionals to enforce legal obligations that conflict with best standards of care out of fear of increased legal risks, ultimately eroding doctor-patient trust. Fear of litigation is a powerful driver of nonconsensual or coercive treatment in obstetrics,[13] one of the most frequently litigated areas of medicine. This fear (perceived or real) has been shown to lead defensive medical practices: interventions chosen to prevent future legal claims rather than providing evidence-based care or respecting patient's choices. In this context, there is a perception that failure to intervene is punished more harshly than non-consensual care.

These dynamics are compounded by systemic issues, such as staff shortages, limited resources and institutional pressures. Hospitals may codify these defensive practices into protocols that emphasize legal risk over patient-centered care. The result is that birthing people may be coerced into interventions, misled or denied the opportunity to make informed decisions about their care. Doctors, nurses, and midwives deserve to work in a legal environment that supports the provision of a positive childbirth experience, centered on respect for pregnant individuals' autonomy, choice, and informed consent.

13 *See, e.g.*, Wouter Bakker et al., *Health workers' perspectives on informed consent for caesarean section in Southern Malawi*, 22 BMC Medical Ethics 1 (2021), *and* Edson L. Rudey et al., Defensive medicine and Cesarean sections in Brazil, 100 Medicine e24176 (2021), *and* Fineschi Vittori et al., *Defensive Medicine in the Management of Cesarean Delivery among Italian Physicians*, 9 Healthcare (Basel) 1097 (2021).

PART 2

The Crisis of Mistreatment in Labor and Childbirth

Prevalence and Patterns of Mistreatment

Despite significant progress in recent decades, the provision of quality maternal healthcare remains a challenge in all regions of the world. In 2020[14], the World Health Organization (WHO) estimated that 287,000 women, or 800 women per day, died due to maternal health complications.[15] Previous WHO research also found that an additional 10-15 million women suffered from life-changing disabilities resulting from complications during pregnancy and childbirth.[16] Concerningly, progress on reducing maternal mortality has stagnated or worsened in most regions of the world since 2015[17], even though it is estimated that 98% of current maternal morbidity and mortality is preventable through the provision of timely and appropriate healthcare.[18]

Mistreatment against pregnant people, particularly those belonging to marginalized communities,[19] has also proven to be pervasive in facility-based childbirth worldwide.[20] Behaviors constituting mistreatment and abuse include forced medical procedures, neglect and denials of care, sexual abuse, and disrespectful and abusive language.[21] The common occurrence of mistreatment during childbirth in healthcare facilities (hospitals, clinics, and birth centers) has been documented in countries around the world.[22] A recent meta-analysis of 25 studies estimated the global prevalence of mistreatment to be 59%, with nonconsensual care being the most prevalent form of mistreatment identified.[23] According to the analysis, the high rates of nonconsensual care in childbirth may stem from systemic and cultural factors within healthcare, with the normalization of harmful practices that are no longer recognized as mistreatment.[24]

Indeed, experts have recognized that at the root of the mistreatment crisis are long-standing oppressive and discriminatory sociocultural norms and values in which pregnant peoples' rights and interests are subordinated to those of

14 The most recent year for which there is comprehensive trend data.

15 Leotine Alkema et al., *Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group*, 387 Lancet (2016), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00838-7/fulltext#seccestitle170; WHO, *Trends in Maternal Mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division* (Feb. 23, 2023), https://www.who.int/publications/i/item/9789240068759 [hereinafter WHO, Trends in Maternal Mortality].

16 WHO, *Millenium Development Goals (MDGs): Factsheet* (Feb. 19, 2018), https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs); WHO, *SDG Target 3.1 Maternal Mortality* (2023), https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality.

17 Alicia Ely Yamin, *Five lessons for advancing maternal health rights in an age of neoliberal globalization and conservative backlash*, 25 Health Hum. Rts. 185 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10309149/.

18 Office of the High Commissioner on Human Rights (OHCHR), Maternal mortality and morbidity and human rights (August 2013), https://www.ohchr.org/sites/default/files/Maternal_mortality_morbidity.pdf.

19 Christina Zampas et al., *Operationalizing a Human Rights-Based Approach to Address Mistreatment against Women during Childbirth*, 22 Health Hum. Rts. 251 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348458/.

20 Meghan A. Bohren et al., *How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys*, 394 Lancet 1750 (2019), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31992-0/fulltext [hereinafter Bohren et al. (2019)]; Meghan A. Bohren et al., *The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review*, 12 PLoS Med (2015), https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847 [hereinafter Bohren et al. (2015)]; Rachelle J. Chadwick et al., *Narratives of distress about birth in South African public maternity settings: A qualitative study*, 30 Midwifery 862 (2014), https://www.sciencedirect.com/science/article/pii/S0266613813003616?via%3Dihub.

21 *Id.*

22 *Id.*

23 Sevil Hakimi et al., *Global prevalence and risk factors of obstetric violence: A systematic review and meta-analysis*, Int J Gynecol Obstet (2025), https://doi.org/10.1002/ijgo.16145.

24 *Id.*

fetuses, and pregnant people are denied the moral or epistemic authority to determine what is best for themselves and the fetuses they carry.[25]

There continues to be a widespread expectation of maternal self-sacrifice that ignores the impact of forced medical treatment and neglect during labor and childbirth. This is compounded with power imbalances that persist in the provider-patient relationship in the maternity care,[26] and a logic of profitability spreading across healthcare systems globally, which prioritizes the best economic results over the health needs of the population and creates poor working environments for providers, characterized by high workload, low pay, inadequate training, and workplace violence.[27]

Mistreatment not only negatively impacts the birthing experience, but also undermines trust in the healthcare system and can deter people from seeking necessary medical care in the future.[28] Evidence shows that mistreatment, or the perception of mistreatment, during pregnancy and childbirth decreases people's willingness to and comfort with giving birth in a healthcare facility.[29] Women across contexts report being afraid of experiencing mistreatment if they give birth in a health facility. The most common fears include being forced to utilize undesirable birth practices, such as unfamiliar or nontraditional birthing positions, unnecessary medical procedures (e.g., painful vaginal exams, episiotomies, unnecessary caesarian sections), and a lack of support or appropriate levels of communication throughout delivery.[30] This fear may restrict a pregnant person's willingness to seek medical care, even in situations where their life, or the life of their fetus, is at risk.

BOX 3: A framework for understanding the types of mistreatment

The typology below is based on Bohren et al. 2015 typology[31] and characterizes the main patterns of autonomy-related mistreatment identified in the literature. It serves as a framework for understanding how different practices, ranging from coercive interventions to the withholding of information, limit the agency of pregnant people and create barriers to rights-based care.

- Psychological, physical, and sexual abuse (nonconsensual vaginal examinations, restricted movement and birthing position, denial of pain relief, threats)
- Stigma and discrimination (negative/harmful gender stereotyping, such as assuming women lack decision-making capacity during labor or minimizing their pain and suffering)
- Failure to meet professional standards of care (forced medical acts or acts performed without informed consent, non-medically necessary procedures, refusal or delay of care)
- Poor communication between the pregnant individual and providers (dismissal of pregnant patient's concerns or requests for information, withholding of information)

25 Special Rapporteur on violence against women, its causes and consequences, Report on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, U.N. Doc. A/74/137 (Jul. 11, 2019); Meghan A. Bohren et al., *Strategies to reduce stigma and discrimination in sexual and reproductive healthcare settings: A mixed-methods systematic review*, 2 PLoS Glob Pub Health e0000582 (2022), https://doi.org/10.1371/journal.pgph.0000582.

26 Marta Schaaf et al., *A critical interpretive synthesis of power and mistreatment of women in maternity care*, 3 PLOS Glob Pub Health e0000616 (2023), https://doi.org/10.1371/journal.pgph.0000616.

27 Bhavya Reddy et al., *A scoping review of the impact of organisational factors on providers and related interventions in LMICs: Implications for respectful maternity care*, 2 PLoS Glob Pub Health e0001134 (2022), https://doi.org/10.1371/journal.pgph.0001134.

28 Zampas et al., *supra* note 19.

29 *Id.*

30 Bohren et al. (2015), *supra* note 20.

31 *Id.*

MISTREATMENT ACROSS THE 12 TARGET COUNTRIES

Research across the twelve target countries has documented the high prevalence of mistreatment, and more specifically, patterns of autonomy violations in labor and childbirth. This includes insufficient, inadequate, or nonexistent informed consent processes for obstetric procedures, poor communication between patients and providers, loss of autonomy and neglect, a lack of choice of birthing position, refusal of a birth companion, and coercion to undergo certain procedures (e.g., c-section, contraception post-childbirth, sterilization).[32] Marginalized populations are more likely to experience these violations of autonomy.[33]

It is difficult to compare the prevalence of mistreatment across studies and countries, as different indicators and methods are utilized, and sample sizes vary significantly. However, based on existing evidence, at least 15% of women across the target countries experienced mistreatment during childbirth, with some studies in countries such as **India**, **Pakistan**, and **Romania** documenting rates as high as 95-100%.[34] Nonconsensual care is reported as the most common form of mistreatment in **Mexico**,[35] **India**,[36] **Spain**,[37] and **Romania**.[38] Similarly, in **Bangladesh**, 53% of patients reported either moderate or severe levels of disrespect and abuse, and 13% of women reported nonconsensual care.[39] In **Pakistan**, ineffective communication was the most common form of mistreatment.[40] For a more detailed breakdown of the available evidence around the prevalence of mistreatment linked to autonomy, informed consent, and choice in the analyzed countries, please see Annex II.

Higher rates of patient neglect and refusal of care have been reported in selected countries in Africa. In **Uganda**, a 2016 study of nearly 400 women found the prevalence of mistreatment to be 41.1%.[41] The most common form of abuse was patient neglect (31.9% of women), and 13.8%

32 *Primera Encuesta Nacional de Parto y Nacimiento*, Movimiento Nacional por la salud sexual y reproductive en Colombia (2024), https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.; *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH)*, Instituto Nacional de Estadística y geografía (INEGI) (2021), https://www.inegi.org.mx/programas/endireh/2021/#documentacion; https://link.springer.com/article/10.1186/s12884-024-06549-1; Timothy Abuya et al., *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya,* 10 PLoS One 4 (2015), https://doi.org/10.1371/journal.pone.0123606.; Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda,* 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.; Reena Sethi et al., *The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery,* 14 Reprod. Health 111 (2017), https://doi.org/10.1186/s12978-017-0370-x.; Abid Faheem, *The nature of obstetric violence and the organisational context of its manifestation in India: a systematic review,* 29 Sex Reprod. Health Matters (2021), https://doi.org/10.1080/26410397.2021.200463; Md Nuruzzaman Khan, Shimlin Jahan Khanam & M. Mofizul Islam, *Disrespect and Abuse Experienced by Mothers While Accessing Delivery Healthcare Services in Bangladesh* (2024) (preprint research article), https://doi.org/10.21203/rs.3.rs-4439968/v1.; Waqas Hameed, Mudassir Uddin, & Bilal Iqbal Avan, *Are underprivileged and less empowered women deprived of respectful maternity care: Inequities in childbirth experiences in public health facilities in Pakistan,* 16 PLoS One (2021), https://doi.org/10.1371/journal.pone.0249874.; Laura Katrina Fraser et al., *Prevalence of obstetric violence in high-income countries: A systematic review of mixed studies and meta-analysis of quantitative studies,* 104 Acta Obstetricia et Gynecologica Scandinavica 13 (2024), https://doi.org/10.1111/aogs.14962; Diana-Elena Neaga, Laura Grünberg, Crina Radu, *Childbirth Experience in Romanian Hospitals: Research Report on Obstetric Violence,* Independent Midwives Association (2024), https://moasele.ro/wp-content/uploads/2024/11/Report-on-Obstetric-Violence_AMI_November_2024.pdf; Saraswathi Vedam et al., *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States,* 16 Reprod. Health 77 (2019), https://doi.org/10.1186/s12978-019-0729-2.

33 Zampas et al., *supra* note 19, at 251.

34 H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis,* 66 J. Postgrad Med. 133 (2020), https://doi.org/10.4103/jpgm.JPGM_648_19; Hameed, Uddin, & Avan, *supra* note 32; Neaga et al., *supra* note 32.

35 *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares* (ENDIREH), Instituto Nacional de Estadística y geografía (INEGI) (2021), https://www.inegi.org.mx/programas/endireh/2021/#documentacion.

36 Ansari & Yeravdekar, *supra* note 34.

37 Fraser et al., *supra* note 32.

38 Neaga et al., *supra* note 32.

39 Khan, Khanam & Islam, *supra* note 32.

40 Hameed, Uddin, & Avan, *supra* note 32.

41 Aaron & Kabakyenga, *supra* note 32.

of women experienced nonconsensual treatment. In **Kenya**, a 2015 study of over 600 women found that 20% of women reported experiencing at least one form of disrespect and abuse, and the two most common forms of disrespect and abuse were non-dignified care (18%) and neglect or abandonment (14.3%).[42] The prevalence of nonconsensual care was low (4.3%). In **Malawi**, a 2022 study of 660 women found that overt abuse occurred in less than 5% of births, yet in 40% of births, there was a lack of consent and engagement in the decision-making process.[43]

In the **United States**, a 2024 Center for Disease Control (CDC) study found that 1 in 5 American women experienced mistreatment during pregnancy and delivery care.[44] The most common forms of mistreatment included receiving no response to requests for help, being shouted at or scolded, a lack of physical privacy, threats of withheld treatment, or coercion into unwanted treatment.[45] Furthermore, 29% of women reported discrimination during maternity care based on age, weight, and income.[46] Black women had the highest reported rates of mistreatment (40%), followed closely by multiracial women (39%), and Hispanic women (29%), while women with no insurance (28%) or public insurance (26%) experienced most mistreatment compared to women with private insurance (16%).[47]

It is important to note that non-consented care is likely underreported, as studies are often based on self-reporting. Studies that have utilized both self-reporting and direct observation by researchers have shown differences between the types of abuse that individuals report and what researchers observe. Similarly, both patients and providers may not always perceive nonconsensual care to be a type of obstetric violence, which could decrease the likelihood of reporting nonconsensual care during a survey or discussion about mistreatment or abuse.[48]

Restoring Respectful Care: The Global Shift Towards a Positive Childbirth Experience

In response to the global crisis of mistreatment, key stakeholders across the world have called for states and healthcare systems to move beyond the single goal of surviving pregnancy towards the guarantee that pregnant people can have a positive childbirth experience.[49] This expanded

42 Abuya et al., *supra* note 32.

43 Carolyn Smith Hughes et al., *Perceptions and predictors of respectful maternity care in Malawi: A quantitative cross-sectional analysis,* 112 Midwifery (2022), https://doi.org/10.1016/j.midw.2022.103403.

44 CDC, *One in 5 women reported mistreatment while receiving maternity care* (Aug. 22, 2023), https://www.cdc.gov/media/releases/2023/s0822-vs-maternity-mistreatment.html.

45 *Id.*

46 *Id.*

47 *Id.*

48 Desirée Mena-Tudela et al., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences,* 17 Int. J. Environ. Res. Public Health 7726 (2020), https://doi.org/10.3390/ijerph17217726; Monicah Andru et al., *Respectful maternity care: Disconnect between perspectives and practices of midwives from a referral hospital in Kampala, Uganda* (2020) (preprint research article) https://doi.org/10.21203/rs.3.rs-103170/v1; Neha Madhiwalla et al., *Identifying disrespect and abuse in organisational culture: a study of two hospitals in Mumbai, India,* 26 Reprod. Health Matters 36 (2018), https://doi.org/10.1080/09688080.2018.1502021.

49 Koblinsky, Marjorie et al., *Quality maternity care for every woman, everywhere: a call to action,* 388 The Lancet 10057, 2307 – 2320; Tunçalp Ö, et al., Quality of care for pregnant women and newborns-the WHO vision, 122 BJOG 1045, 1045-49 (2015); WHO, *WHO recommendations: intrapartum care for a positive childbirth experience* (February 7, 2018), https://www.who.int/publications/i/item/9789241550215 [hereinafter WHO, Recommendations for a positive childbirth experience]. *See also,* WHO, *Global Strategy for Women's, Children's and Adolescents' Health* (2016–2030), and the Every Woman Every Child movement, the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf (who.int)

focus has required improving the quality of maternal healthcare with an emphasis on ensuring a pregnant person's right to respectful maternity care (RMC).

The WHO has been a global leader in the shift towards quality and respectful maternity care. In a 2014 *Statement on the prevention and elimination of disrespect and abuse during facility based childbirth*, the WHO recognized mistreatment as a human rights issue and called on Member States to "initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care."[50] Later, the WHO adopted new *Standards for improving quality of maternal and newborn care in health facilities* to inform the development of relevant national- and local-level health policies and clinical protocols.[51] Issued in 2016, the guideline calls on States to pay greater attention to the quality of their maternal health services by ensuring that every woman and newborn has access both to "skilled care at birth with evidence-based practices" and care that is delivered in a "humane, respectful, supportive environment."[52]

In 2018, the WHO issued specific guidelines on *Intrapartum care for a positive childbirth experience*, recognizing a "positive childbirth experience" as a critical maternal health outcome for the reduction of maternal mortality. The guidelines implement a holistic and human rights-based approach and recommend the provisions of RMC interventions[53] to achieve a positive childbirth experience in labor and childbirth. It is important to note that what represents a positive childbirth experience will vary among pregnant individuals, but the research suggests that for most, it makes them feel supported, in control, safe, and respected.[54]

A focus on quality, respectful maternity care centered on ensuring autonomy, dignity, and respect during childbirth is now widely recognized in different public health initiatives.[55] Many regional and international human rights experts and bodies have called for States to protect pregnant people against mistreatment during childbirth and ensure their rights to autonomy and informed consent when accessing maternal healthcare.[56] National efforts have also increased, with some countries enacting laws on obstetric violence, and a stream of policy guidelines around the world directed at service providers to promote the implementation of RMC.[57]

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50 WHO, *WHO Statement, The prevention and elimination of disrespect and abuse during facility-based childbirth*, at 2, https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1.

51 WHO, *WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*, https://www.who.int/publications/i/item/9789241511216.

52 *Id.* at 5.

53 See WHO, Recommendations for a positive childbirth experience, at 19 (defining RMC as "care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth").

54 *Id.* at 3. See also Julia Leinweber et al., *Developing a woman-centered, inclusive definition of positive childbirth experiences: A discussion paper*, 50 Birth 362, (2022), https://doi.org/10.1111/birt.12666; Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women's Childbirth Experiences*, 21 The Journal of Perinatal Education, 158 (2012), https://doi.org/10.1891/1058-1243.21.3.158; Janet Bryanton et al., *Predictors of women's perceptions of the childbirth experience*, 37 J Obstet Gynecol Neonatal Nurs 24 (2008), https://doi.org/10.1111/j.1552-6909.2007.00203.x.

55 *See, e.g.,* International Childbirth Initiative, *Global Initiative to provide guidance and support for safe and respectful maternity care* developed by The International MotherBaby Childbirth Organization (IMBCO) and the International Federation of Gynecology and Obstetrics (FIGO), among other partners.

56 *See, e.g.,* Special Rapporteur on violence against women, its causes and consequences, *Report on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* (2019) (U.N. Doc. A/74/137); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report on violence and its impact on the right to health* (2022) (U.N. Doc. A/HRC/50/28).

57 *See, e.g.,* Centre for Parenting Culture Studies, *Programme: Policing Pregnancy Conference,* University of Kent (April 23, 2016), https://blogs.kent.ac.uk/parentingculturestudies/pcs-events/previous-events/policing-pregnancy/programme/.

PART 3

Insights and Findings

Human Rights Standards on Autonomy in Childbirth: Progress and Gaps

Over the past decade, numerous UN and regional human rights bodies have raised concern about the widespread mistreatment of pregnant people in facility-based childbirth and called on states to ensure the provision of dignified and respectful healthcare during labor and childbirth. Most recently, certain regional and international human rights bodies have addressed the human rights implications of mistreatment in childbirth – often referred to as obstetric violence – particularly the rights to life, health, personal integrity, and freedom from discrimination.[58] Despite this important progress, key dimensions of mistreatment remain underdeveloped or inadequately addressed, particularly those that implicate informed consent and choice during labor and childbirth.[59]

MISTREATMENT AND INFORMED CONSENT

The principles of autonomy, informed consent, and refusal in medical interventions are well-established in international and regional human rights norms and standards.[60] Bodies such as the Inter-American Court of Human Rights (IACtHR) and the European Court of Human Rights (ECtHR) have recognized that informed consent requires health providers to give patients adequate, accurate, and understandable information to make a free choice regarding treatment and care, enabling patients to freely accept or refuse recommended treatment options.[61]

Human rights bodies have also recognized the right to informed consent as an integral part of reproductive health and rights.[62] Forced sterilization and forced abortion have been established as violations of the right to reproductive autonomy and private life, and in some instances, as a violation of the right to be free from inhuman and degrading treatment.[63] Jurisprudence on forced sterilization has clarified that exceptions to informed consent in emergency situations are valid only when there is an immediate and serious risk to the life or health of the patient,[64] not merely a potential future risk.[65]

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58 Brítez Arce et al. v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 474 (Nov. 16, 2022).

59 Zampas et al., *supra* note 19. *See also* Rajat Khosla et al., *International Human Rights and the Mistreatment of Women During Childbirth,* 18 Health Hum. Rts. 131 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5394989/.

60 *See* I.V. v. Bolivia, Inter-Am Ct. H.R. (ser. C) No. 336 (Nov. 30, 2016); Inter-Am Ct. H.R., Poblete Vilches v. Chile, Inter-Am. Ct. H.R. (ser. C) No. 349 (Mar. 8, 2018); Reyes Jimenez v. Spain, App. No. 57020/18, Eur. Ct. H.R. (Mar. 8, 2022); M.A.K. and R.K. v. United Kingdom, App. No. 45901/05, Eur. Ct. H.R. (Mar. 23, 2010); CESCR, *General Comment No. 14 on the Right to Health,* UN Doc. No. E/C.12/2000/4, para. 8 (2000); Convention on the Rights of Persons with Disabilities (CRPD), Arts. 15 and 25. *See also* Universal Declaration on Bioethics and Human Rights of 2005, Art. 6; *and* Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Oviedo Convention of 1997), Art. 5.

61 *See* I.V. v. Bolivia, Inter-Am Ct. H.R. (ser. C) No. 336 (Nov. 30, 2016); Inter-Am Ct. H.R., Poblete Vilches v. Chile, Inter-Am. Ct. H.R. (ser. C) No. 349 (Mar. 8, 2018); Reyes Jimenez v. Spain, App. No. 57020/18, Eur. Ct. H.R. (Mar. 8, 2022); M.A.K. *and* R.K. v. United Kingdom, App. No. 45901/05, Eur. Ct. H.R. (Mar. 23, 2010).

62 *See, e.g.,* I.V. v. Bolivia, Inter-Am Ct. H.R. (ser. C) No. 336 (Nov. 30, 2016); Maria Mamerita Mestanza-Chavez v. Peru, Petition 12.191, Inter-Am. Ct. H.R., Report No. 71/03, OEA/Ser.L/V/II.118, doc. 5 rev. 2 (2003); CEDAW, S.F.M. v. Spain, No. 138/2018 (Feb. 28, 2020); CEDAW, N.A.E. v. Spain, No. 149/2019 (Jul. 13, 2022); CEDAW, M.D.C.P. v. Spain, No. 154/2020 (Feb. 24, 2023); Y.P. v. Russia, App. No. 43399/13, Eur. Ct. H.R. (Jun. 11, 2013).

63 *See, e.g.,* I.V. v. Bolivia, Inter-Am Ct. H.R. (ser. C) No. 336 (Nov. 30, 2016); Maria Mamerita Mestanza-Chavez v. Peru, Petition 12.191, Inter-Am. Ct. H.R., Report No. 71/03, OEA/Ser.L/V/II.118, doc. 5 rev. 2 (2003); CEDAW, S.F.M. v. Spain, No. 138/2018 (Feb. 28, 2020); CEDAW, N.A.E. v. Spain, No. 149/2019 (Jul. 13, 2022); CEDAW, M.D.C.P. v. Spain, No. 154/2020 (Feb. 24, 2023); Y.P. v. Russia, App. No. 43399/13, Eur. Ct. H.R. (Jun. 11, 2013).

64 *See, e.g.,* V.C. v. Slovakia, App. No. 18968/07, Eur. Ct. H.R. (Nov. 8, 2011) (finding a nonconsensual sterilization violated the patient's rights because the sterilization was not a life-saving procedure).

65 I.V. v. Bolivia, Inter-Am Ct. H.R. (ser. C) No. 336 (Nov. 30, 2016); V.C. v. Slovakia, App. No. 18968/07, Eur. Ct. H.R. (Nov. 8, 2011); Y.P. v. Russia, App. No. 43399/13, Eur. Ct. H.R. (Jun. 11, 2013). *See also,* the former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, explicitly recognized that violations to informed consent in reproductive healthcare can amount to torture or ill-treatment. He affirmed that medical necessity can never justify bypassing informed consent, even in emergency situations (U.N. Doc A/HRC/31/57, para. 45 (2016)).

Recently, there has been emerging caselaw on the issue of mistreatment and the lack of consent during labor and childbirth. In a series of landmark decisions, the CEDAW Committee recognized that cumulative forms of abuse and mistreatment during pregnancy, including the practice of nonconsensual treatment, constitute obstetric violence and violate the rights to health, personal integrity, and freedom from gender-based discrimination.[66] For instance, in the case of *N.A.E. v. Spain* (2022) the Committee determined that the failure to obtain a patient's informed consent during childbirth, including for vaginal examinations, the administration of oxytocin, and cesarean sections, constituted obstetric violence. In 2023, in the case of *M.D.C.P. v. Spain*, the Committee reinforced its jurisprudence, holding that quality healthcare includes obtaining full informed consent for procedures such as the application of epidural anesthesia and a cesarean section.

Similarly, recent rulings from the IACtHR held that the State's failure to provide timely and adequate emergency obstetric care during childbirth constituted obstetric violence.[67] In its decision in the case *Britez Arce v. Argentina* (2022), the IACtHR determined that obstetric violence is a violation of human rights law, expressed in the "tendency to pathologize natural reproductive processes during pregnancy, childbirth, and postpartum."[68] The Court observed that obstetric violence also includes a failure to fully inform the pregnant person about their medical condition and available treatments, as well as a failure to ensure access to accurate and timely information about their reproductive and maternal health.[69]

BOX 4: UN Special Procedures Confront Mistreatment and Unconsented Treatments in Childbirth

To date, perhaps the most comprehensive analysis of the human rights implications of mistreatment and informed consent violations comes from the former UN Special Rapporteur on violence against women, its causes and consequences, Dr. Dubravka Šimonović. In a 2019 report, the Special Rapporteur framed mistreatment and violence in maternity care as a widespread form of gender-based violence and as a violation of the rights to equality and non-discrimination, life, health, privacy, autonomy, freedom from violence, and freedom from inhuman and degrading treatment.[70] Crucially, the Special Rapporteur highlighted informed consent in reproductive health services and childbirth as a fundamental human right, and defined it as an ongoing communication that must be voluntary, fully informed, required *regardless of the procedure*, and can be withdrawn at any point. The report called for various state actions, including ensuring effective and proper applications of informed consent, and respecting women's autonomy, integrity, and their capacity to make informed decisions during pregnancy and childbirth, including through legal strengthening.

66 CEDAW, M.D.C.P. v. Spain, No. 154/2020 (Feb. 24, 2023), para. 7.7.
67 Brítez Arce et al. v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 474 (Nov. 16, 2022); Caso Rodriguez Pacheco y Otra v. Venezuela, Inter-Am. Ct. H.R. (ser. C) No. 504 (Sept. 1, 2023).
68 Brítez Arce et al. v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 474 (Nov. 16, 2022), Para. 81-82.
69 Brítez Arce et al. v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 474 (Nov. 16, 2022).
70 Dubravka Šimonović (Special Rapporteur on violence against women, its causes and consequences), *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* (U.N. Doc. A/74/137) (2019). Similarly, the Working Group on Discrimination Against Women in Law and Practice has documented how denying women autonomous decision-making in healthcare perpetuates stigma and discrimination. See Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice,* (U.N. Doc. A/HRC/32/44) (2016).

More recently, the Special Rapporteur on the right to health, Dr. Tlaleng Mofokeng, has linked obstetric violence, including nonconsensual surgical procedures, to broader forms of structural violence rooted in colonialism, racism, and socioeconomic inequality. Her groundbreaking work highlights the enduring health and psychological impacts of such mistreatment, including gynecological problems, obstetric complications, mental health illnesses, including anxiety and depressive disorders, increased substance misuse, and suicide, among others.[71]

Despite this significant progress, gaps and challenges remain in how international and regional courts interpret legal protections to autonomy and informed consent during pregnancy and childbirth. For example, some decisions appear to suggest that autonomy and informed consent obligations may change or be weakened based on pregnancy status. There is a lack of caselaw or legal interpretation that affirms or gives content to the right to refuse medically recommended treatment.

While the CEDAW Committee's decisions are extremely important in recognizing the problem of obstetric violence and overmedicalization during childbirth, they also weakened general standards on informed consent. According to these decisions, informed consent is only required for *invasive* treatments performed during childbirth.[72] There is no argumentation or explanation of the basis for this standard, which contradicts contemporary medical, ethical, and legal norms, which hold that consent is required for *any* medical procedure, regardless of perceived severity.[73] The CEDAW Committee has also allowed for exceptions to informed consent in "situations where the life of the mother and/or baby is at risk" without clarification of how such a broad exception should be interpreted.[74] As such, this standard leaves excessive discretion for health professionals to override a patient's consent.

Similarly, although the *Britez Arce* ruling issued by the IACtHR includes important considerations about obstetric violence and the State's duties to ensure patients are provided with information about pregnancy-related risks and treatment alternatives before any procedure, the Court does not mention the obligation to obtain voluntary, informed consent.[75] In practice, this reinforces narratives in which it suffices that pregnant patients are informed of decisions already made, rather than being offered genuine alternatives or empowering autonomous decision-making.

In another decision by the IACtHR, *Pacheco Rodriguez v. Venezuela* (2023), the Court determined the doctor's treatment amounted to obstetric violence and violated the patient's rights to health and physical integrity.[76] After suffering complications from a cesarean section, the patient

71 Tlaleng Mofokeng (Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health), *Report on violence and its impact on the right to health*, (U.N. Doc. A/HRC/50/28) (2022).
72 CEDAW, S.F.M. v. Spain, No. 138/2018 (Feb. 28, 2020), para. 8(b)(i).
73 *See, e.g.*, WMA, *Medical Ethics Manual*, at 43 (2015), https://www.wma.net/wp-content/uploads/2016/11/Ethics_manual_3rd_Nov2015_en.pdf (determining a patient "has the right to give or withhold consent to any diagnostic procedure or therapy"). *See also* American Medical Association, Opinion 2.1.1 *Informed Consent*, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (establishing the requirements for informed consent for "medical treatment" and "recommended treatments").
74 CEDAW, S.F.M. v. Spain, No. 138/2018 (Feb. 28, 2020), para. 8(b)(i).
75 Brítez Arce et al. v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 474 (Nov. 16, 2022).
76 Caso Rodriguez Pacheco y Otra v. Venezuela, Inter-Am. Ct. H.R. (ser. C) No. 504 (Sept. 1, 2023).

requested a total hysterectomy, but her attending doctor refused and proceeded with a different course of treatment without obtaining consent from the patient. Due to his refusal, the patient suffered complications and had to undergo three different surgeries, which created long-term health problems that affected her personal and professional life. The Court agreed that the doctor's treatment had interfered with the patient's rights to judicial guarantees and protections, as well as the patient's right to personal integrity and to live a life free from violence. Nonetheless, the Court did not address the failure to obtain prior and informed consent of the patient, as well as the provider's refusal to proceed with the patient's requested treatment that ultimately violated the patient's rights to personal freedom, privacy, and dignity.

BOX 5: Pain, Vulnerability, and Decision-Making in Labor

There is extensive caselaw affirming that informed consent is a legal prerequisite to sterilization. International and regional bodies have further stressed that such consent cannot be validly obtained during labor or immediately postpartum. This position stems from the recognition that sterilization is not a life-saving procedure and does not meet the threshold for emergency interventions where consent requirements may be adjusted. However, these decisions generally frame the pregnant people's perceived "vulnerability" during and after labor as justification to bar consent. While critical as a safeguard against coercion, this framing can inadvertently undermine the autonomy of birthing people by suggesting that labor is inherently incapacitating. While some individuals may experience impaired capacity due to pain, trauma, or emotional intensity, giving birth does not inherently make someone incapable of decision-making. A more nuanced approach is needed – one that protects against coercive sterilization, while affirming the enduring capacity and agency of pregnant people during and after labor.

FREEDOM TO CHOOSE THE CIRCUMSTANCES AND MANNER OF GIVING BIRTH

Issues concerning freedom of choice during childbirth, including decision-making around the circumstances, manner, and setting of giving birth, have received limited attention by supranational jurisprudence. For example, the ECtHR has ruled on these issues on only a few occasions. Notably, the Court has affirmed that under article 8 of the European Convention on Human Rights, the right to respect private and family life protects the right to choose the circumstances around one's birth. This includes decisions to have medical students observe one's birth, to allow for medical treatment of a newborn, or to have a planned home birth.[77] Any restrictions should meet the requirements of legality, legitimate aim, necessity, and proportionality. However, since then, the Court has rejected the choice of homebirth and supported that States have no legal obligation to facilitate them, invoking the State's interest in protecting the health and safety of the child and mother during and after delivery.[78]

77 Ternovsky v. Hungary, App. No. 67545/09, Eur. Ct. H.R. (Dec. 14, 2010); Konovalova v. Russia, App. No. 37873/04, Eur. Ct. H.R. (Oct. 9, 2014); Hanzelkovi v. the Czech Republic, App. No. 43643/10, Eur. Ct. H.R. (March 11, 2015).

78 See, Dubská and Krejzová v. the Czech Republic, Apps. Nos. 28859/11 and 28473/12, Eur. Ct. H.R., para. 188-189 (Nov. 15, 2016).

BOX 7: Planned Home Births under European Human Rights Law

In its first ruling regarding assisted planned home births, *Ternovsky v. Hungary* (2010),[79] the Court affirmed that Article 8 of the European Convention on Human Rights on the right to respect for private and family life protects the right to choose the circumstances around one's birth.[80] The Court established that this right implies the legal and institutional environment that enables that choice, except where other rights render the restriction necessary. For the Court, the choice in matters of child delivery includes the legal certainty that the choice is lawful and not subject to sanctions, directly or indirectly. Here, the State failed to meet the requirement of legal certainty, since the applicant was not free to choose to give birth at home because of the permanent threat of prosecution faced by health professionals and the absence of specific and comprehensive legislation on the subject.

However, in *Dubská and Krejzová v. the Czech Republic* (2016), the Grand Chamber of the Court limited the impact of the *Ternovsky* ruling. While the Court reaffirmed that the decision of a pregnant person around the circumstances of birth is fundamentally linked to their right to private life, it found that a law that prohibited health providers from assisting home births was compatible with the European Convention.[81] The Grand Chamber accepted that the national authorities had a considerable margin of appreciation when regulating the question of home births, for which there was no European consensus. In the applicants' case, the Grand Chamber considered that the State's legal framework encouraged hospital births for the safety of the mother and child,[82] and claimed there was a higher risk for mother and newborn in home births, even with a midwife attending.[83] Subsequent rulings on home births by the Court, in *Pojatina v. Croatia* (2018),[84] and in *Kosaitė-Čypienė and others v. Lithuania* (2019)[85] have followed the Grand Chamber's doctrine and rejected alleged violations.

National Framework

POSITIVE LEGAL AND POLICY DEVELOPMENTS

Protections related to autonomy, informed consent, and patient choice were found in multiple legal and regulatory frameworks across the twelve countries and jurisdictions reviewed. This includes general healthcare laws (Colombia and Mexico), patients' rights laws or charters (Spain, Kenya, Uganda, Florida, and Texas), sexual and reproductive health laws (Pakistan and Spain), and healthcare professional regulations (India, Bangladesh, Brazil, Malawi, and Colombia). In all countries reviewed, unconsented care may be subjected to penalties under disciplinary, civil, and criminal laws, or addressed under consumer protection legislation.

Notably, our research highlights a positive trend across several countries towards strengthening legal protections for patients' rights. In the last decade, governments have introduced or updated legislation aimed at affirming the rights to autonomy, dignity, and informed consent in

79 Ternovsky v. Hungary, *supra* note 77.
80 Ternovsky v. Hungary, *supra* note 77.
81 Dubská and Krejzová v. the Czech Republic, *supra* note 78.
82 Dubská and Krejzová v. the Czech Republic, *supra* note 78, ¶ 172.
83 *Id.*
84 Pojatina v. Croatia, App. No. 18568/12, Eur. Ct. H.R. (Oct. 4, 2018).
85 Kosaité-Čypiené and Others v. Lithuania, App. No. 69489/12, Eur. Ct. H.R. (Jun. 5, 2019).

healthcare. These developments signal a growing recognition of patients' legal entitlements and reflect increasing efforts to improve the alignment of domestic laws with international human rights norms and standards.

Recent Legal Reforms on Patients' Rights and SRHR across the target countries

Country / Jurisdiction	Law/Reform	Year	Topics
Colombia	Statutory Health Law	2015	Recognizes health as a fundamental right; affirms patient autonomy and dignity
Kenya	Health Act	2017	Codifies patient rights, including the right to informed consent
India	Charter of Patients' Rights (proposed by NHRC)	2018	Enumerates rights such as informed consent and refusal; formally adopted by the National Council for Clinical Establishments and the National Health Authority
Pakistan	Sindh Reproductive Healthcare Rights Act	2019	Protects rights to informed, voluntary, and respectful reproductive healthcare
Spain	Organic Law on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy (LO 1/2023)	2023	Strengthens autonomy in reproductive health decisions, recognizes dignified maternal care
India	National Medical Commission (NMC) Ethics and Medical Registration Board Regulations	2023	Replaces earlier Medical Council regulations; includes detailed provisions on professional duties regarding informed consent
Mexico	Reforms to the general health law	2023	Expands protections for informed consent and patient autonomy, particularly protections for people with disabilities in healthcare

Furthermore, our research identified efforts in many countries to adopt laws or regulations that specifically promote humanized, dignified, and respectful maternity care. These laws have been approved nationally in Colombia and at the state level in Mexico, Brazil, and Spain.

- In **Colombia**, Law 2244/2022 on Dignified, Respectful, and Humanized Childbirth outlines several rights that women have during pregnancy, labor, and delivery. These include the right to receive comprehensive, adequate, truthful, timely, and efficient care; to be treated with respect and without discrimination; to privacy and confidentiality; and to have a respectful and humanized birth. During childbirth, the law also protects the right of women to have a companion of their choice, and includes freedom of movement, adoption of preferred

birthing position, use of pharmacological and non-pharmacological pain management, and pushing in accordance with the physiological sensation of the person. Regarding postnatal decisions, the law recognizes the woman's choice to breastfeed, participate in skin-to-skin contact, and to have the placenta delivered to them per their beliefs.

- Certain states in **Brazil** have enacted laws regulating certain forms of mistreatment.
  - » In the state of **São Paulo**, Law No. 17,137/2019 guarantees the right of the parturient to choose a cesarean section starting from 39 weeks of gestation, regardless of medical indication, after being fully informed about the benefits of natural childbirth and the risks associated with cesarean deliveries.[86] However, the law also allows for medical discretion: if a healthcare provider disagrees with the choice of the parturient, they can refer her to another professional.
  - » In **Rio de Janeiro**, Law No. 7687 recognizes the right of every pregnant person to humanized care during pregnancy, childbirth, and postpartum.[87] This includes the right to receive care that is free from discrimination, centered on the wishes of the pregnant person, and respects their autonomy, dignity, needs, and demands.[88] The law also establishes the right of pregnant people to develop a birth plan. Any deviation from the birth plan, or procedures that are unnecessary or prejudicial to the health of the pregnant person or fetus, lack scientific support, or may cause harm requires a written explanation to the pregnant person.[89] Other protections in the law include freedom of movement, preferred birthing positions, and ingestion of liquids and light food, barring any medical contraindication.
- In Mexico, states have opted for different ways to regulate obstetric violence and protect the rights of pregnant people. For instance:
  - » The states of **Aguascalientes**, **Campeche**, **Chiapas**, **Chihuahua**, **Colima**, **Guerrero**, **Mexico**, **Morelos**, **Nayarit**, **Puebla**, **Querétaro**, **Quintana Roo**, **San Luis Potosí**, **Sinaloa**, **Tamaulipas**, **Tlaxcala**, and **Zacatecas** have recognized obstetric violence as a violation of pregnant people's rights as part of their laws on gender-based violence. Under its law protecting women against violence, **Mexico City** has expanded the definition of humanized birth as care that respects the pregnant person's rights to dignity, integrity, liberty, and freedom to make decisions related to where, with whom, and how they want to give birth.
  - » **Nuevo Leon** has a specific law on humanized birth and dignified maternity, detailing the rights of pregnant people to informed consent for all procedures and medication used throughout birth and labor. **Tlaxcala** defines humanized birth as a model of care that prioritizes the dignity of the woman as the protagonist of her birth and recognizes her right to make decisions about her delivery.
  - » The states of **Baja California**, **Baja California Sur**, **Sonora**, **Veracruz**, and **Yucatán** have health laws specifically protecting maternal health rights, including informed consent and autonomy, and specific rights like preferred birthing positions.

86 Lei No. 17,137, de 24 de agosto de 2019, Ordinário de São Paulo SP (Braz.)
87 Lei No. 7.687, de 5 de Dezembro de 2022, Ordinária de Rio de Janeiro RJ; Art. 1 (Braz.).
88 *Id.* at Art. 2.
89 *Id.* at Art. 10.

Most countries have relied on policies to implement principles of autonomy, choice, and informed consent in the provision of RMC. We identified over 50 maternal healthcare policies and service delivery guidelines that seek to advance these rights. For example:

- In India, the State developed the **Labour Room Quality Improvement Initiative**, commonly referred to as LaQshya, a nationwide initiative intended to improve labor, childbirth, and post-partum care with a patient-centered approach rooted in scientific evidence.[90] These guidelines are the first to identify the need for RMC, defining it as "respect for the woman's autonomy, dignity, feelings, privacy, choices...and consideration for personal preferences including option for companionship during the maternity care."[91] The guidelines instruct healthcare staff to provide privacy to the pregnant woman, allow the presence of a birth companion, and give them the freedom to choose a comfortable position during labor.[92]
- Through policy guidelines, Malawi adopted the World Health Organization's **Standards for Improving Quality of Maternal and Newborn Care**. These evidence-based standards emphasize respecting the mother's choices and refraining from subjecting mothers and newborns to unnecessary medical practices during labor, childbirth, and the early postnatal period. Further, pregnant patients must "receive sufficient information about the care and have effective interactions with staff to make informed decisions."[93] Specifically, women "are informed about their rights and options for care and encouraged to ask questions. They are supported in making decisions about all aspects of their care and treatment; their personal values are respected, and their consent is obtained before procedures are carried out."[94]
- Bangladesh's **National Guidelines for Midwives** state midwifery care is "underpinned by the principles of respect for women and families, informed choice and autonomous practice"[95] and establishes within their scope of work the "important task in education and the promotion of health for the woman...the midwife has the responsibility to inform the woman in relation to all aspects of her care, and to advocate for women."[96] The guidelines uplift RMC, defined as "care that focuses on the interpersonal aspect of maternity care that emphasizes the fundamental rights of mothers, newborns, and families, and protects the mother-baby pair."[97] RMC is recognized as a human right, where all women have the right to respect, choice, and preference, and is an essential component of the patient's rights to autonomy, dignity, feelings, choices, and preferences.[98]

90 Ministry of Health & Family Welfare [India], *Labour Room Quality Improvement Initiative (LaQshya)* (2017), at 1, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf.
91 *Id.* at p. 1, FN 1.
92 *Id.* at p. 2.
93 Government of Malawi, *Standards for Improving Quality of Maternal and Newborn Care in Malawi* (2020), at 31, https://platform.who.int/docs/default-source/mca-documents/policy-documents/by-country/mwi/mwi-malawi-mnh-qoc-standards-final-ccx21-fu-e5ugm6ary3hd-d4w.pdf?Status=Master&sfvrsn=2ec4250b_2.
94 *Id.*
95 Directorate General of Nursing and Midwifery [Bangladesh], *National Guidelines for Midwives* (2017), at 8, https://dgnm.portal.gov.bd/sites/default/files/files/dgnm.portal.gov.bd/page/18c15f9c_9267_44a7_ad2b_65affc9d43b3/2021-06-24-11-25-23141d2949e-9295a21b4564983984047.pdf.
96 *Id.*
97 *Id.* at 11.
98 *Id.*

GAPS, CHALLENGES, AND RISKS

Despite these positive developments, our research identified various ways in which existing laws and regulations either explicitly limit maternal autonomy or fail to provide adequate protections.

1. Legal Frameworks Provide for Ambiguous and Overly Broad Exceptions to Informed Consent in Emergency Situations

When there is a need to proceed with emergency treatment to save the life of the patient or to avoid significant harm to their health, *and* the patient is unable to give consent, *and* an appropriate advance directive or surrogate is not possible to obtain consent,[99] it is generally permissible (by most legal and ethical frameworks) for healthcare professionals to provide critically needed care under the principle of "presumed consent." However, this is not a blanket authorization; it is an exception that requires concrete and well-defined conditions to be met concurrently.

Out of the twelve countries reviewed, ten had the right to informed consent explicitly recognized in their laws and regulations (Brazil,[100] Colombia,[101] India,[102] Kenya,[103] Malawi,[104] Mexico,[105] Pakistan,[106] Romania,[107] Spain,[108] and Texas[109] and Florida[110] in the United States). In Bangladesh[111] and Uganda,[112] explicit informed consent provisions are found in the code of ethics issued by their respective national medical councils. Of these countries, all but Bangladesh and Pakistan provide for emergency or medical necessity exceptions to informed consent.

However, in most cases, these exceptions fail to provide specific criteria or justifying

99 Convention on Human Rights and Biomedicine (Oviedo Convention) (1997), Arts. 6 and 8, https://rm.coe.int/168007cf98 =. *See also* WMA, *International Code of Medical Ethics* (2023), Art. 17, https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/; *and* ACOG, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, Committee Opinion No. 819 (2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology [hereinafter ACOG, Committee Opinion No. 819].

100 Lei No. 10,406/2002, Institui o Codigo Civil, Art. 15, (Braz.) "Ninguém pode ser constrangido a submeter-se, com risco de vida, a tratamento médico ou a intervenção cirúrgica." *See also* Enunciados Aprovados na VI Jornada do Direito Civil (Approved Statements on the VI Civil Law Conference), Enunciado 533, https://www.emagis.com.br/static/emagis2/arquivos/downloads/vi-jornada-de-direito-civil-2121810.pdf (explaining the informed consent process in medical care).

101 L. 1751/2015, febrero 16, 2015, Art. 10(d) (Colom.).

102 National Medical Commission, Registered Medical Practitioner (RMP) (Professional Conduct) Regulations, Art. 19(A) (issued on Aug. 2, 2023) (India). *See also* National Council on Clinical Establishments, Charter of Patients' Rights and Responsibilities, Art. IV (issued on Aug. 23, 2021) (India), http://clinicalestablishments.gov.in/WriteReadData/3181.pdf.

103 Ministry of Health, The Kenya National Patient's Rights Charter (2013), Art. 8, https://kmpdc.go.ke/resources/PATIENTS_CHARTER_2013.pdf.

104 Gender Equality Act, 2014, Part VI, § 20 (Malawi) (stating healthcare professionals "must impart all information necessary for a person to make a decision regarding *whether or not to undergo any procedure or accept any service* affecting his or her sexual and reproductive health...before performing any procedure or offering any service") (emphasis added).

105 Ley General de Salud (LGS), Art. 51 Bis 1, Diario Oficial de la Federación [DOF] 07-02-1984, últimas reformas DOF 07-06-2024 (Mex.)

106 Reproductive Healthcare and Rights Act (2010), § 2(i) (Pak.), https://na.gov.pk/uploads/documents/1302319237_781.pdf.

107 Patients' Rights Law no. 46 of 21 of January 2003, Arts. 4-6 (Rom.), https://extranet.who.int/mindbank/item/2207; Law no. 95/2006 on healthcare reform, Art. 660 (Rom.), https://www.anm.ro/en/_/LEGI%20ORDONANTE/Titlul%20XVIII_Med_2016_EN%20.pdf.

108 Ley básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica art. 3 (B.O.E. 2002, 274) (Spain), https://www.boe.es/buscar/pdf/2002/BOE-A-2002-22188-consolidado.pdf; Ley orgánica de salud sexual y reproductiva y de la interrupción voluntaria del embarazo art. 27(a) (B.O.E. 2010, 55) (Spain), https://www.boe.es/buscar/act.php?id=BOE-A-2010-3514.

109 Tex. Civ. Prac. & Rem. § 74.101 (2023); 22 Tex. Admin. Code § 190.8 (2024).

110 Fl. Stat. § 766.103 (2024).

111 Uganda has a non-binding Patients' Rights Charter, which outlines a patient's right to informed consent. See Ministry of Health, Patient Rights and Responsibilities Charter, art. 10 (2019) (Uganda), https://library.health.go.ug/sites/default/files/resources/Final%20copy%20of%20the%20PATIENT%20RIGHTS%20%26%20RESPONSIBILITY%20CHARTER%281%29.pdf. Bangladesh regulates informed consent under the Code of Professional Conduct issues by the Medical and Dental Council. See Bangladesh Medical and Dental Council, Code of Professional Conduct, Etiquette and Ethics, § 2.3.1, https://www.bmdc.org.bd/docs/EthicsBookMakeupfinal.pdf.

112 Uganda Medical and Dental Practitioners Council, Code of Professional Ethics, art. 7(b) (2023), https://guluhospital.net/wp-content/uploads/2023/02/Code-of-Professional-Ethics-1.pdf.

conditions, including requiring that the patient lack decision-making capacity for presumed consent to apply. Legal frameworks contain contradictory or ambiguous language regarding what constitutes an emergency as the basis for presumed consent. Rather than requiring a clearly defined, imminent, and life-threatening situation, laws and regulations lack clarity on how to determine whether an emergency exists.

For instance, Brazil's Federal Supreme Court and the Medical Commission have recognized the possibility of exempting requirements for informed consent "during medical or surgical procedures that cannot be interrupted."[113] While Uganda's Patient's Rights and Responsibilities Charter is not legally binding, it provides for exceptions to informed consent when "in the opinion of the medical practitioner he/she feels the requirement of informed consent can be waived."[114] According to Malawi's Code of Medical Ethics, informed consent is optional. The Code only urges "all practitioners to ensure that *as far as possible* informed consent is obtained"[115] (emphasis added), leaving ample room for interpretation and potential circumvention.

Kenya's Health Act also provides exceptions to informed consent, allowing healthcare providers to bypass informed consent when the patient is unable to consent and is being treated in an emergency, *or* when delays in provision of healthcare will result in death or irreversible damage to the patients' health and the patient has not expressly or by implication refused the treatment.[116] The language of the provision does not require all these conditions to occur together, weakening protections. Similarly, Kenya's National Patient's Rights Charter only provides an emergency exception[117] and does not require the patient cannot also consent to the treatment. In Colombia, an emergency is recognized as an exception to informed consent in Law 23 de 1981 (Standards of Medical Ethics) and by jurisprudence of the Constitutional Court. The Law provides that physicians must request the patient's consent to perform medical and surgical treatments except in cases "where this is not possible" or "unless the urgency of the case requires immediate intervention."[118] No further guidance is given. A more recent law regulating the right to health (Law 1751/2015) does not mention any exceptions.[119] A 2016 ruling by Colombia's Constitutional Court (C-182-16) indicated that informed consent can be presumed when the person is "unconscious," "or particularly altered, or in grave risk of death."[120]

113 Enunciados Aprovados na VI Jornada do Direito Civil (Approved Statements on the VI Civil Law Conference), Enunciado 533, https://www.emagis.com.br/static/emagis2/arquivos/downloads/vi-jornada-de-direito-civil-2121810.pdf. See also Conselho Federal de Medicina, *Resolução* No. 2,217/2018, pg. 14 (2018) (Braz.), https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2018/2217.

114 Ministry of Health, Patient Rights and Responsibilities Charter, art. 10 (2019) (Uganda), https://library.health.go.ug/sites/default/files/resources/Final%20copy%20of%20the%20PATIENT%20RIGHTS%20%26%20RESPONSIBILITY%20CHARTER%281%29.pdf

115 Code of Ethics and Professional Conduct, ¶ 5.6 (2013) (Malawi), https://zachimalawi.blogspot.com/2013/05/code-of-ethics-for-medical-council-of.html.

116 The Health Act, No. 21 (2017) Kenya Gazette Supplement No. 101 § 9.

117 Ministry of Health, The Kenya National Patient's Rights Charter (2013), Art. 8, https://kmpdc.go.ke/resources/PATIENTS_CHARTER_2013.pdf.

118 L. 23/81, 18 de febrero, 1991, por la cual se dictan normas en materia ética médica, art. 15 (Colom.), https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=68760

119 *See* L. 153/87, 15 de Agosto, 1987, por la cual se adiciona y reforma los codigos nacionales, art. 2 & 5 (Colom.); *and* Corte Constitucional [C.C.] [Constitutional Court], 18 de enero 1996, Sentencia C-055/96 (establishing how to resolve issues of precedence and relevance in the law – the newest law supersedes the oldest, and if there is a contradiction between the two, regulatory norms must be established to resolve the issue).

120 *See generally* Corte Constitucional [C.C.] [Constitutional Court], 13 de abril 2016, Sentencia C-182/2016 (Colom.).

Defining an emergency in obstetrics: While this issue affects all patients, it presents additional challenges for the birthing person. Unlike many other fields of medicine, obstetrics frequently equates risk to the birthing person or the fetus with an emergency, even in the absence of immediate, life-threatening danger. In the practice of obstetrics, this is particularly problematic as the idea of what constitutes an emergency tends to have a broader interpretation than in other medical fields, as virtually no choice, procedure, or event related to pregnancy and childbirth can be seen as risk-free. This can lead to routine interventions being presented as urgent, creating a rationale for circumventing informed consent. Further, in obstetric care, risk is often assessed primarily in terms of the consequences of *not* intervening, with assessments of the risks associated with those interventions relegated.[121] The substantial disparity between the recommended utilization of obstetric procedures, such as c-sections,[122] episiotomies,[123] digital vaginal examinations,[124] and other interventions by medical professionals are evidence that pregnant people are often unwillingly subject to medically unnecessary procedures with no demonstrated benefit on their health, usually without their informed consent.

Determining Capacity of the Laboring Person: Another distinct issue regarding presumed consent during labor and delivery is the absence of clear legal criteria for determining when a laboring person can be deemed incapacitated. While the principle of informed consent rests on the presumption that the adult patient has the capacity to make healthcare decisions unless formally determined otherwise, most legal frameworks reviewed do not clearly define what constitutes "incapacity." In Colombia and India, for instance, vague terms like "altered," "agitated", and "violent" may be used to justify deeming patients incapacitated.[125]

As discussed earlier, this lack of specific criteria is particularly problematic in childbirth, where natural physiological and emotional responses such as pain, fear, or disorientation may be misinterpreted as incapacity.

While pain during labor may be intense, it does not automatically impair a person's capacity to make decisions, and the assumption that someone in labor cannot understand information or express wishes fuels harmful stereotypes of pregnant people being inherently incapable.

Pregnant people are also disproportionately affected by discriminatory assumptions and gender-based stereotypes that portray them as irrational, overly emotional, vulnerable, or incapable of understanding and therefore unable to make autonomous choices. A lack of capacity is also often assumed simply because the birthing person disagrees with medical advice or asserts their autonomy. Unless there is clear evidence of incapacity

121 ACOG, *Refusal of Medically Recommended Treatment During Pregnancy*, Committee Opinion No. 664 (2019), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy

122 Bohren et al. (2019), *supra* note 20.

123 *Id. See also* Marit van der Pijl et al., *The Ethics of Consent During Labour and Birth: Episiotomies*, J. of Med. Ethics 1 (2023), https://jme.bmj.com/content/early/2023/01/30/jme-2022-108601.

124 Bohren et al. (2015), *supra* note 21.

125 *E.g.*, Corte Constitucional [C.C.] [Constitutional Court], 13 de abril 2016, Sentencia C-182/2016 (Colom.) (indicating informed consent can be waived when the person is "particularly altered"); *and* National Medical Commission, Registered Medical Practitioner (RMP) (Professional Conduct) Regulations, Art. 19(A) (issued on Aug. 2, 2023) (India).

(unconsciousness), birthing people are presumed competent and entitled to make decisions on their care. In cases where the birthing person lacks legal capacity, supported decision-making should take place. Finally, entering a hospital or agreeing to a birth plan does not mean consenting to all subsequent procedures. Implied consent does not replace the need for ongoing, explicit informed consent, especially for high-risk or invasive procedures: birthing people do not lose the right to consent simply because labor has begun.

BOX 8: A Word of Caution on Legal Interference[126]

When creating exceptions to fundamental rights, such as informed consent and refusal, legal frameworks must provide clear definitions and basic guidance. Without well-defined criteria, such as what constitutes an emergency or the requirement that the patient lacks decision-making capacity, there is a danger that the exception to informed consent will effectively nullify the rule. Legal clarity helps ensure consistency in care and respect for patients' rights and safety. However, legislative and regulatory efforts should avoid prescribing specific elements of patient care, including interfering with clinical decision-making. The goal of the legislator is to strike a careful balance: respecting professional judgment while safeguarding patients' rights to informed consent through clear and evidence-based legal frameworks.

2. Legal frameworks allow for refusal to be overridden in the name of fetal protection

While nearly all the countries reviewed, except for Pakistan and Bangladesh, explicitly recognize a patient's right to refuse treatment,[127] in some countries, laws and jurisprudence undermine this right in the context of pregnancy by prioritizing the interests of the fetus.

In Brazil, for example, Federal Medical Council Resolution No. 2.232/2019 affirms that a pregnant person's refusal of treatment may be overridden if it is deemed to threaten fetal life or health. Specifically, the Resolution views pregnant women's refusal "from the mother-fetus binomial perspective", and considers such refusal as an abuse of rights[128] and therefore may be overridden.[129] Similarly, Uganda also provides that refusal of treatment may occur, but "the health provider has the right to perform the treatment against the patient's will if the health worker has confirmed the following conditions...*Protection of the unborn,* minor, or disadvantaged person and Court order."[130]

126 See ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2025), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2025/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physicianrelationship#:~:text=ACOG%20opposes%20any%20governmental%20interference,judgment%20when%20caring%20for%20patients.

127 E.g., Gender Equality Act, 2014, Part VI, § 20(1)(d) (Malawi) (recognizing the rights of patients to make a decision regarding whether *or not* to undergo any procedure or accept any service); and Ley General de Salud (LGS), Art. 51 Bis 1, Diario Oficial de la Federación [DOF] 07-02-1984, últimas reformas DOF 07-06-2024 (Mex.); *and* National Medical Commission, Registered Medical Practitioner (RMP) (Professional Conduct) Regulations, Art. 19(A) (issued on Aug. 2, 2023) (India); Fla. Stat. § 381.026(4)(b)(4); L. 2244/22, 11 de julio 2022, Diario Oficial [D.O.], art. 5 (Colom.)

128 Conselho Federal de Medicina, *Resolução* No. 2.232/2019, Art. 5 (2019) (Braz.), https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2019/2232.

129 This overriding of the patient's rights has been mimicked in state legislation. *E.g.*, Lei No. 7.687, de 5 de Dezembro de 2022, Ordinária de Rio de Janeiro RJ; Art. 1 (Braz.) (stating the pregnant person's wishes may be overridden by the healthcare provider "in case of risk to the health of the pregnant person or the unborn child").

130 Ministry of Health, Patient Rights and Responsibilities Charter, art. 12(b)(ii) (2019) (Uganda), https://library.health.go.ug/sites/default/files/resources/Final%20copy%20of%20the%20PATIENT%20RIGHTS%20%26%20RESPONSIBILITY%20CHARTER%281%29.pdf

Even in the absence of explicit legal exceptions to informed refusal, courts have imposed treatment on pregnant people in the name of fetal protection. In one case from São Paulo, Brazil,[131] a pregnant patient sought damages against the hospital, claiming she was denied the presence of her chosen birth companion and was forced to undergo a cesarean section, despite her request for a natural birth. The court ruled that fetal protection was a medical justification for the cesarean section and found no negligence on the part of the physician. A similar case occurred in Rio de Janeiro, where a patient claimed that she had been forced to undergo a cesarean section and denied the presence of her designated companion.[132] The court dismissed the patient's claim, citing medical evidence that a normal delivery would have posed a risk to the fetus. Moreover, the court justified the exclusion of the chosen companion, asserting that her disagreement with the cesarean section could have caused a disruption in the delivery room. The following cases further illustrate this issue in the United States[133] and Spain.

BOX 9: Case Snapshot

Pemberton v. Tallahassee Memorial Regional Medical, United States (1999)

Laura Pemberton was in labor, attempting vaginal delivery at home, but was forced through a State-requested court order to submit to a cesarean section, allegedly because it was medically necessary to protect the life of the unborn fetus. The District Court for Northern Florida found there was no violation of her constitutional rights, nor did the hospital act negligently under state law. The Court determined that the State's interest in preserving the life of the unborn child preceded that of Ms. Pemberton, particularly because she was at full term, and the fetus was at viability. Citing *Roe v. Wade*, the Court noted that the intrusion after viability that was permitted in *Roe*, namely denying an abortion and forcing a woman to stay pregnant, was greater than requiring a woman to undergo a cesarean section for a wanted baby. Thus, in this case, the State's interest outweighed the mother's rights.

Sentencia No. 66/2022, June 2, 2022 (Constitutional Court no. 129) (Spain)

A pregnant woman had planned to have an at-home birth, but since her pregnancy was longer than 42 weeks, hospital staff reported her and obtained an order to forcefully commit her to the hospital and have a c-section. Although the Constitutional Court recognized that the circumstances surrounding childbirth were protected under the right to privacy, dignity, and personal autonomy, the Court determined the forceful commitment of the applicant to the hospital was lawful because the State had a legitimate interest in protecting the life and health of the nasciturus (fetus). The Court concluded the measure was proportionate to the violation of the applicant's rights, as failure to commit the pregnant person would result in a risk to the fetus's life, and there was no alternative measure that would protect the fetus.

These cases demonstrate the dangers of invoking the State's interest in protecting prenatal life to exercise judicial control over decisions regarding labor and childbirth. Unlike abortion cases, which involve the certain and intentional termination of pregnancy, compelled treatment in pregnancy and childbirth cases does not concern the life of the fetus.[134] They

131 TJ-SP, Civil Appeal No. 1001330-40.2021.8.26.0176, Appeal Court Judge Maria Laura Tavares, decided on February 15, 2024.
132 TJ-RJ, Civil Appeal No. 0042482-76.2015.8.19.0213, Appeal Court Judge Maria Helena Pinto Machado, decided on February 11, 2022.
133 In re Browning, 568 So.2d 4, 14 (Fla.1990) (reaffirming that physicians may overcome a person's right to refuse medical intervention if there's an overriding compelling state interest, which must refer to: (1) the preservation of life; (2) the protection of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession. The Court has specifically stated that "Generally, the state interest in the preservation of life is considered the most significant"). *See also* Pub. Health Tr. of Dade Cnty. v. Wons, 541 So.2d 96 (Fla. 1989).
134 See Margo Kaplan, *"A Special Class of Persons": Pregnant women's right to refuse medical treatment after Gonzalez v. Carhart,* 13 UPenn J Constitutional L 145, 169-174 (2011).

involve disagreements about how best to achieve a healthy birth and what constitutes acceptable risk. These decisions ignore that childbirth is inherently variable and that medical knowledge is not absolute, but evolves over time.

In the *Pemberton* case in **Florida**, the Court found that the risk to fetal life of a vaginal birth after cesarean (VBAC) was "unacceptably high." At the time of the decision (1999), expert testimony presented conflicting estimates of the risk of uterine rupture, ranging from 2% to as high as 6%, with some claiming that such rupture could lead to a 50% chance of fetal death. These were not definitive conclusions, but rather disputed and probabilistic assessments of relatively low risk. Notably, medical knowledge has since evolved. By 2025, VBAC has been widely recognized as a safe option for most women, with recent studies indicating that the overall rate of intrauterine rupture is between 0.5% and 1%, depending on the individual risk factors.[135]

Ultimately, at the center of these cases, there is rarely a clear threat to the life of the fetus, but rather a disagreement over what constitutes acceptable risk – risks that are themselves uncertain, contested, and often subject to evolving medical opinion.

BOX 10: Positive Practice

Romania's Society of Obstetrics and Gynecology and the College of Doctors have issued a series of medical guides, which have been adopted by the nation by Order 1241/2019, on the approval of obstetrics-gynecology guidelines. The **Guidelines on Caesarean Section**[136] requires that informed consent be obtained for either a c-section or vaginal birth. This guideline specifically notes that the doctor shall respect the patient's refusal of any proposed treatment, including a c-section, even if the surgery has a clear and evident benefit for the mother and/or fetus.

The American College of Obstetricians and Gynecologists (ACOG) has developed two different opinions on informed consent and refusal of medically recommended care during pregnancy and childbirth. The first opinion, **No. 819, on Informed Consent and Informed Decision Making in Obstetrics and Gynecology**, outlines the requirements for valid informed consent and notes that it allows refusals of treatment or care.[137] The only exception to providing care without consent is in life-threatening emergencies where the patient is not able to consent and there is no available advance directive or surrogate. In Opinion **No. 664, on Refusal of Medically Recommended Treatment during Pregnancy**, the College highlights how pregnancy does not affect the patient's ability to make decisions or refuse treatment, and pregnancy status should not exempt patients from the general protections of informed consent.[138] The opinion encourages healthcare staff to consider the patient's reasoning, lived experiences, and values to understand the context of the patient's decision-making. Finally, it emphasizes that coercion is never permissible, including the use of courts to mandate medical interventions, and the patient's wishes should be respected when treatment is refused.

135 Aaron B. Caughey, *Informed consent for a vaginal birth after previous cesarean delivery*, 54 J Midwifery Women's Health 249 (2009), https://doi.org/10.1016/j.jmwh.2009.02.010.
136 Society of Obstetrics and Gynecology of Romania, *Clinical guidelines on obstetrics and gynecology from 2019 to the present*, https://sogr.ro/ghiduri-clinice-2019-prezent/.
137 ACOG, Committee Opinion No. 819.
138 ACOG, *Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals*, Committee Opinion No. 830 (2021). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/07/reproductive-health-care-for-incarcerated-pregnant-postpartum-and-nonpregnant-individuals.

3. Legal frameworks make humanized care and choice during labor and childbirth contingent on good health status

Pregnant people should have the right to choose the circumstances and manner of giving birth, including making decisions on where and with whom they give birth, method of delivery, the use of pharmacological and non-pharmacological pain management, and postpartum care decisions for themselves and their baby. In the 12 countries reviewed, this freedom is not comprehensively recognized in laws, regulations, or jurisprudence. In general, most countries addressed these issues in policy and service-delivery guidelines.

Comprehensive protections to the right to choose the circumstances and manner of birth were only found in countries that have enacted specific legislation on dignified and humanized care, such as Colombia and states in Mexico and Brazil. While these laws are of critical importance, they contain provisions that indicate that the right to humanized and respectful care is conditional on the birthing person and the unborn child having good health and the absence of medical risk. In other words, when medical risks arise, autonomy must yield.

- In **Mexico**, the Federal Health Ministry issued regulations that allow for midwives (those more often considered to be providers of respectful maternity care) and traditional birth attendants to assist only *in "low-risk, full-term" births*, and for women to birth vertically if *the space and personnel allow for it*.[139] Additionally, it promotes spontaneous childbirth *if there are no medical or obstetrical contraindications*.[140]
- Similar language is found in **Colombia**'s Law 2244/2022, on Dignified, Respectful and Humanized Childbirth. Article 12 provides that women have the right to a respected and humanized birth, based on updated scientific evidence, with a differential approach, *as long as the health conditions of the woman and the fetus allow it and their free determination*."[141] Article 12 (24) also states that women have the right "to be informed about the feasibility of having a vaginal birth after a cesarean section ..., *as long as the good health conditions of the fetus and the woman are ensured*."
- In **Brazil**, **São Paulo**'s Law no. 17,137/2019 on C-Sections and Methods of Delivery protects the rights of pregnant people to choose a c-section after 39 weeks of gestation, regardless of whether there is a medical need for it or not.[142] Yet, it restricts the autonomy of the pregnant person to choose normal delivery to situations where "*clinical conditions for it are present*." **Rio de Janeiro**'s Law No. 7687 contains certain problematic exceptions in the provision of maternal health care. For example, it recognizes the rights of pregnant women to informed consent, but only for invasive procedures, and except in cases of emergency that pose a risk of death to the mother or baby.[143] It also restricts a pregnant person's right to choose natural and less invasive methods for pain relief in

139 Norma Oficial Mexicana, NOM-007-SSA2-2016, Para la atención de la mujer durante el embarazo, parto y puerperio, y de la persona recién nacida, § 5.1.11, Diario Oficial de la Federación [DOF], 07-04-2016 (Mex.).
140 *Id.* at § 5.5.5.
141 L. 2244/22, 11 de julio 2022, Diario Oficial [D.O.], art. 12 (Colom.)
142 Lei No. 17,137, de 24 de agosto de 2019, Ordinário de São Paulo SP (Braz.)
143 Lei No. 7.687, de 5 de Dezembro de 2022, Ordinária de Rio de Janeiro RJ; Art. 2 (Braz.).

situations where their decisions do not imply a risk to their or the unborn fetus's safety.[144] In protecting a person's right to a birth plan and preemptively designating healthcare choices, the law specifically explains that the pregnant person's wishes may be overridden by the healthcare provider "*in case of risk to the health of the pregnant person or the unborn child*."[145]

This conditional framing creates a false dichotomy between protecting autonomy and ensuring safety, even though medical necessity does not extinguish the rights to bodily autonomy, choice, informed consent, and refusal. These provisions also reinforce paternalistic models of care in obstetrics, where healthcare professionals are the ones who know what is best for the pregnant person.

BOX 11: A False Dichotomy: Choice vs. Safety in Childbirth

Maternity care is often shaped by a perceived trade-off between patient autonomy and clinical safety, as if respecting a pregnant person's choices must be set aside when medical risk is involved. This framing is misleading. It conditions rights like informed consent and respectful care on the absence of complications, eliminating the agency of those deemed "high risk".

Yet autonomy and safety are not opposing goals. Evidence-based care that respects choice, informed consent, and refusal can and must coexist with efforts to protect health outcomes. Upholding pregnant people's rights is not a barrier to safety: it is one of its essential components.

4. Some legal frameworks still allow for the withholding of information in healthcare

In certain jurisdictions, therapeutic privilege is awarded to healthcare professionals. There are differing degrees of potential harm that the patient may be exposed to that allow therapeutic privilege. Some may require it cause extreme emotional, psychological, or physical harm, while others may use vague or broader language that provides greater discretion to the healthcare provider. For example, **Kenya**'s Health Act allows healthcare providers to withhold information when it "*would be contrary to the best interests of the user*"[146] and instructs them to inform the next of kin or guardians instead.

Similarly, **Brazil**'s Code of Medical Ethics recognizes therapeutic privilege as another exception to informed consent. The Code states that "failing to inform the patient of a diagnosis, prognosis, risks and objectives of the treatment, *except when direct communication could cause harm to the patient*, in which case he must communicate with his legal representative."[147] Resolution No. 1 of the FCM clarifies that therapeutic privilege may be used in cases where revealing the truth about the patient's condition could result in serious

144 *Id.* at Art. 3.
145 *Id.* at Art. 4.
146 The Health Act, No. 21 (2017) Kenya Gazette Supplement No. 101 § 12.
147 Conselho Federal de Medicina, Resolução No. 2,217/2018, pg. 27 (2018) (Braz.), https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2018/2217.

psychological harm, to the point of constituting a reason to waive obtaining consent.[148] In **Uganda**'s Patients' Rights and Responsibilities Charter, therapeutic privilege is allowed if the healthcare provider feels that sharing the information "is *likely to cause severe harm* to the patient's mental or physical health."[149] In **Florida**, a patient has the right to information "unless it is *medically inadvisable* or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative."[150]

The use of therapeutic privilege raises significant human rights and ethical concerns, particularly in the context of childbirth and maternity care. Withholding information deprives pregnant people of the ability to weigh the risks and benefits of different options based on their values, preferences, and life circumstances. It places the provider as a gatekeeper of truth, undermining the patient's capacity to make decisions about their body and health. Withholding information also often coincides with heightened concerns about fetal risk and fear of litigation, leading to coerced interventions, diminished communication, and eroded trust in the doctor-patient relationship.

5. Legal Remedies Focus on Individual Accountability, Not Systemic Reform

Remedies available for rights violations in maternal healthcare vary across all selected countries. Most often, pregnant people who have suffered violations may seek relief under criminal or civil law by looking at medical negligence laws or presenting complaints before professional disciplinary boards. Thus, available remedies may include financial compensation, jail or prison, fines against the provider, or suspension or revocation of professional licenses. Notably, these schemes appear to only be focused on individual responsibility and are not designed to drive system-level improvements that go beyond one doctor, one hospital, or even one geographical area.

Of particular concern are those remedies found in laws enacted in several states in **Mexico** criminalizing obstetric violence, an approach adopted by other countries in Latin America. These laws generally define obstetric violence broadly, use terms that can be subject to various interpretations, and do not require the intent to cause harm. For example, Chiapas's criminal provision states "The crime of obstetric violence is committed by anyone who appropriates the body and reproductive processes of a woman, expressed in dehumanizing treatment, abuse in the supply of medication or pathologization of natural processes, resulting in the loss of autonomy and the ability to decide freely about one's body and sexuality."[151] Penalties range from one to three years in prison, up to 200 days of fines, suspension from practice, and/or repayment for the damage caused.

148 Conselho Federal de Medicina, *Recomendação No. 1/2016, Dispõe sobre o processo de obtenção de consentimento livre e esclarecido na assistência médica*, pg. 14 (2016), https://portal.cfm.org.br/images/Recomendacoes/1_2016.pdf

149 Ministry of Health, Patient Rights and Responsibilities Charter, art. 10 (2019) (Uganda), https://library.health.go.ug/sites/default/files/resources/Final%20copy%20of%20the%20PATIENT%20RIGHTS%20%26%20RESPONSIBILITY%20CHARTER%281%29.pdf

150 Fla. Stat. § 381.026(4)(b)(3).

151 Codigo Penal Chiapas [CPC], Art. 183 Ter., https://juntalocal.chiapas.gob.mx/pdf/marco_juridico/CODIGO_PENAL_PARA_EL_ESTADO_DE_CHIAPAS.pdf.

While criminalizing obstetric violence is symbolically powerful, it risks creating legal and practical tensions that may ultimately undermine the very protections it seeks to guarantee. Terms such as "pathologizing natural processes" or "dehumanizing treatment" are vague and can be deeply subjective. Without clear definitions or standards of intent, they can create an unacceptable level of legal uncertainty for those obliged by the law, drive the practice of defensive medicine, erode patient-provider trust, and chill healthcare professionals' commitment to respectful maternity care.

Most importantly, criminal laws that broadly punish "obstetric violence" fail to address the root causes of mistreatment and violence in maternal healthcare. Global health and human rights bodies have consistently pointed to systemic factors, such as chronic understaffing, lack of resources, inadequate training, gender bias, and burnout, as key drivers of mistreatment. A punitive approach that singles out individual practitioners ignores those structural realities.

Conclusion and Recommendations

Legal frameworks play a critical role in shaping the quality and dignity of maternity care. Our research highlights that while important efforts have been made in recognizing patient rights, including autonomy, choice, informed consent, and refusal, these protections are often undermined by vague exceptions, risk-based limitations, or the prioritization of fetal interests over those of the pregnant person.

Protecting autonomy and ensuring safety are not mutually exclusive goals. When designed well, legal frameworks can serve both. Respect for pregnant people's rights to bodily autonomy must be the foundation of maternal health systems, not the exception.

To create a truly enabling legal environment and eradicate mistreatment, legal frameworks must unambiguously affirm that the pregnant person retains full decisional authority during childbirth, incorporating the following elements:

1. Anchor Legal Frameworks in Human Rights

Legislation designed to address mistreatment in childbirth should ensure a human rights-based approach to childbirth, recognize the pregnant person as the primary decision-maker of their care, and ensure their rights to life, health, bodily autonomy, equality, and non-discrimination, amongst others. Further, laws should seek to provide a positive birth experience and respectful maternity care. Rights enshrined in legislation should be protected in *all* pregnancies, regardless of perceived maternal or fetal risk.

2. Clearly Defined Rights and Legal Standards

Legislation should explicitly guarantee:

- The right to informed consent and refusal throughout pregnancy, labor, and delivery;
- The right to make decisions that may contradict medical advice, family opinion, or perceived fetal interests; and
- The right to choose the circumstances and manner of birth, including birth setting, delivery method, and pain management.

Laws must clarify that pregnancy, labor, and childbirth do not create an exception to informed consent or diminish decision-making capacity.

3. Narrowing and Clearly Limiting Emergency Exceptions

Emergency exceptions to informed consent should apply only when:

- The person is incapacitated, and
- No advance directive or proxy is available, and
- Immediate intervention is required to prevent death or serious harm

Capacity must be presumed. Labor pain, disagreement with medical advice, or emotional distress should never be assumed as incapacity.

4. Protect the Right to Refuse Treatment

Legal frameworks should affirm that competent pregnant persons have the right to refuse treatment, including during pregnancy, labor, and delivery. The right to refuse should be recognized even when treatment is considered to be necessary for the patient's health or survival, the patient's fetus, or both. Forced court-ordered medical interventions during childbirth should be recognized as violations of privacy, dignity, and bodily integrity.

5. Ensure Legal Safeguards against Coercion and Therapeutic Privilege

Laws should include clear protections against coercive tactics in maternity care. This includes discouraging the use of threats of legal action or withdrawals of care. The use of therapeutic privilege (withholding of information for perceived benefit) should also be discouraged.

6. Reject Criminalization and Punitive Approaches

Criminalizing "obstetric violence" through vague or subjective definitions risks creating fear-based, defensive medicine and undermines the provision of respectful maternity care. Instead, remedies should address the systemic failures that result in the violation of reproductive rights rather than focusing on sanctioning or blaming individual providers, especially in those cases where the system-structure in which the provider operates leaves little room for providing a patient-centered model of care. While overly broad criminalization should be avoided, efforts to address specific actions that may amount to obstetric violence or reproductive harm, such as forced sterilization, may rely on criminal and penal codes.

7. Mandate Provider Training and Data Gathering

Legislation addressing maternal health rights should also require data gathering from designated agencies and institutions to better understand the extent of mistreatment and abuse in childbirth. Healthcare staff and anyone involved with the provision of maternal healthcare should also be required to receive regular training on the rights of pregnant patients and the consequences for failing to uphold them. This training should also seek to inform healthcare staff on best practices and timely updates on evidence-based care.

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ANNEX 1.

Autonomy and Informed Consent – Relevant Legislation, Regulations, and Codes of Conduct across Analyzed Countries

Bangladesh

1. Penal Code of 1860
2. Consumers' Rights Protection Act of 2009
3. Code of Professional Conduct, Etiquette and Ethics (Bangladesh Medical & Dental Council)

Brazil

FEDERAL LEGISLATION

1. Lei No. 8,080, de 19 de setembro de 1990
2. Lei No. 9,263, de 12 de janeiro de 1996
3. Lei No. 10,406, de 10 de janeiro de 2002 (Código Civil)
4. Lei No. 11,634, de 27 de dezembro de 2007

FEDERAL MEDICAL COUNCIL RECOMMENDATIONS

1. Recomendação CFM No. 1/2016
2. Resolução CFM No. 2,217/2018
3. Resolução CFM No. 2,232/2019
4. Resolução CFM No. 2,284/2020

STATE LEGISLATION

1. Paraná, Lei No. 19,701, de 20 de novembro de 2018
2. São Paulo, Lei No. 17,137, de 23 de agosto de 2019
3. Pará, Lei No. 9,016, de 29 de janeiro de 2020
4. Rio de Janeiro, Lei No. 7,687, de 5 de dezembro de 2022
5. Paraná, Decreto No. 11,570 de 30 de junho de 2022

Colombia

1. Law 23/1981, Standards of Medical Ethics
2. Law 1751/2015, Regulation of the Fundamental Right to Health
3. Law 2244/2022, on Dignified, Respectful and Humanized Childbirth

India

1. Penal Code of 1860
1. Consumer Protections Act of 1986
2. Clinical Establishment Act Standard for Hospital (Level 1), Standard No – CEA/Hospital 001 (Regulations issued by National Council for Clinical Establishments)
3. Charter of Patients' Rights (National Human Rights Commission)
4. Registered Medical Practitioner (Professional Conduct) Regulations 2023 (National Medical Commission)

Kenya

1. Patients' Rights Charter
2. The Health Act of 2017

Malawi

1. Penal Code
2. Gender Equality Act of 2013
3. Code of Ethics and Professional Conduct (Medical Council)

Mexico

FEDERAL LEGISLATION

1. Ley General de Salud
2. Ley General de Acceso de las Mujeres a una Vida Libre de Violencia
3. Norma Oficial Mexicana NOM-007-SSA2-2016
4. Norma Oficial Mexicana NOM-020-SSA-2025

STATE LEGISLATION

1. Ley General de Acceso de las Mujeres a una Vida Libre de Violencia: Aguascalientes, Campeche, Chiapas, Chihuahua, Ciudad de México, Colima, Estado de México, Guerrero, Morelos, Nayarit, Puebla, Querétaro, Quintana Roo, San Luis Potosí, Sinaloa, Tamaulipas, Tlaxcala, Zacatecas
2. Ley de Protección a la Maternidad: Baja California, Baja California Sur, Coahuila, Durango, Nuevo León, Sonora, Veracruz, Yucatán
3. Constitución Política: Chiapas, Durango
4. Ley de Salud: Colima, Jalisco, Morelos, San Luis Potosí, Tamaulipas, Tlaxcala
5. Código Penal: Aguascalientes, Chiapas, Estado de México, Guerrero, Puebla, Quintana Roo, Veracruz, Yucatán

Pakistan

1. Reproductive and Healthcare Rights Act of 2010
2. Sindh Reproductive Healthcare Rights Act
3. Khyber Pakhtunkhwa Reproductive Healthcare Rights Act

Romania

1. Law no. 95/2006 on health reform
2. Patients' Rights Law no. 46/2003
3. Order of the Minister of Health no. 1410/2016 on the approval of the Norms for the application of the Law on Patients' Rights no. 46/2003, published in the Official Gazette, Part I, no. 1009 of 15 Decembre 2016, as further amended
4. Order of the Minister of Health no. 1241/2019 on the approval of obstetrics-gynecology guidelines, published in the Official Gazette, Part I no. 738 of 10 September 2019, as further amended

Spain

1. Ley 14/1986, General de Sanidad
2. Ley 41/2022, Law on the Regulation of Autonomy, Rights, and Information of the Patient
3. Ley Órganica 1/2023, Sexual and Reproductive Rights and the Voluntary Interruption of Pregnancy

Uganda

1. Patients' Rights and Responsibilities Charter (not legally binding)
2. Penal Code

United States

FEDERAL LEGISLATION

1. Code of Federal Regulations
2. Affordable Care Act
3. Emergency Medical Treatment and Labor Act
4. Patient Self-Determination Act of 1990

STATE LEGISLATION

1. Florida Medical Consent Law
1. Florida Patient's Bill of Rights and Responsibilities
1. Texas Civil Practice and Remedies Code
1. Texas Health & Safety Code

ANNEX 2.

Prevalence of different forms of obstetric violence across target jurisdictions

This Annex presents prevalence rates of mistreatment linked to autonomy, informed consent and choice as reported in the different studies identified across the analyzed countries.

Form of mistreatment	Prevalence
Mistreatment / obstetric violence overall	**LAC** • **BRA:** 44.3% of women reported that they had experienced some form of mistreatment during childbirth. This rate was higher for women who had a vaginal birth (44.1%) compared to those that had a cesarian section (35.9%).[152] • **MEX:** 31.4% of women aged 15 to 49 experienced some form of violence during childbirth.[153] **AFRICA:** • **KEN:** A 2015 study found that 20% of women reported experiencing at least one form of disrespect and abuse.[154] • **UGA**: There are no comprehensive, national-level studies exploring maternal mistreatment in Uganda. A 2016 study in southwestern Uganda found the prevalence of abuse was 41.1%.[155] **ASIA:** • **BGD**: 53% of mothers reported either moderate or severe levels of disrespect and abuse. The prevalence of disrespect and abuse was 33% higher in government facilities as compared to private facilities, and higher among women with less education and women in lower wealth quintiles.[156] • **IND**: A 2020 meta-analysis documented the prevalence of disrespect and abuse ranging from 20% to 100% across different states and hospital settings, with an overall prevalence of 71%.[157] • **PAK:** Two 2018 studies estimated the prevalence of mistreatment during childbirth to be 97%[158] and 99.7% respectively.[159] **EUROPE:** • **ESP**: The overall prevalence of obstetric violence in Spain ranges from 26% to 67%.[160] • **ROU:** The prevalence of obstetric violence ranges from 76.4% to 95.5%, depending on the type of delivery. Vaginal births had a higher prevalence of obstetric violence (95.5%) than c-sections, with 26% of respondents delivering via vaginal birth reporting 10+ experiences of obstetric violence; comparatively, elective c-sections had the lowest prevalence of obstetric violence (76.4%). [161] **UNITED STATES:** • **USA**: A 2019 survey documented that 17.3% of participants experienced some form of obstetric violence. Women of lower socioeconomic status experienced more discriminatory care as compared to women of higher socioeconomic status (21.5% vs 15%, respectively). There is a clear racial divide within the data: some form of obstetric violence was reported by 32.8% of Indigenous women, 25.0% of Hispanic women, 22.5% of Black women, and 21.1% of Asian women, compared to 14.1% of white women. [162] More recently, a 2023 study found that 20.4% of respondents experienced at least one type of mistreatment during childbirth.[163]

152 Sample size: ~24,000. *In* Tatiana Henriques Leite et al., *The association between mistreatment of women during childbirth and postnatal maternal and child health care: findings from "Birth in Brazil"*, 35 Women and Birth 28 (2022), https://doi.org/10.1016/j.wombi.2021.02.006; Maria Regina Torloni, Ana Pilar Betrán, & José M. Belizán, *Born in Brazil: shining a light for change*, 13 BMC Reproductive Health 133 (2016), https://doi.org/10.1186/s12978-016-0247-4

153 Sample size: 3,535. *In Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH)*, Instituto Nacional de Estadística y geografía (INEGI) (2021), https://www.inegi.org.mx/programas/endireh/2021/#documentacion.

154 Sample size: 641. *In* Timothy Abuya et al., *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya*, 10 PLoS One 4 (2015), https://doi.org/10.1371/journal.pone.0123606

155 Sample size: 374. *In* Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda*, 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.

156 Sample size: 891. *In* Md Nuruzzaman Khan, Shimlin Jahan Khanam & M. Mofizul Islam, *Disrespect and Abuse Experienced by Mothers While Accessing Delivery Healthcare Services in Bangladesh* (2024) (preprint research article), https://doi.org/10.21203/rs.3.rs-4439968/v1.

157 Explored the findings of 7 articles. *In* H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis*, 66 J. Postgrad Med. 133 (2020), https://doi.org/10.4103/jpgm.JPGM_648_19.

158 Sample size: 1,334. *In* Waqas Hameed & Bilil Iqbal Avan, *Women's experiences of mistreatment during childbirth: A comparative view of home and facility-based births in Pakistan*, 13 PLoS One 3 (2018), https://doi.org/10.1371/journal.pone.0194601.

159 Sample size: 360. *In* Zainab Azhar, Oyinlola Oyebode & Haleema Masud, *Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care*, 13 PLoS One (2018), https://doi.org/10.1371/journal.pone.0200318.

160 Laura Katrina Fraser et al., *Prevalence of obstetric violence in high-income countries: A systematic review of mixed studies and meta-analysis of quantitative studies*, 104 Acta Obstetricia et Gynecologica Scandinavica 13 (2024), https://doi.org/10.1111/aogs.14962.

161 Sample size: 5,623. *In* Diana-Elena Neaga, Laura Grünberg, Crina Radu, *Childbirth Experience in Romanian Hospitals: Research Report on Obstetric Violence*, Independent Midwives Association (2024), https://moasele.ro/wp-content/uploads/2024/11/Report-on-Obstetric-Violence_AMI_November_2024.pdf.

162 Sample size: 2,138. *In* Saraswathi Vedam et al., *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*, 16 Reprod. Health 77 (2019), https://doi.org/10.1186/s12978-019-0729-2.

163 Sample size: 2,403. *In* Yousra A. Mohamoud et al., *Vital Signs: Maternity Care Experiences — United States, April 2023*, 72 MMWR Morb. Mortal. Wkly Rep. 961 (2023), http://dx.doi.org/10.15585/mmwr.mm7235e1.

Form of mistreatment	Prevalence
Psychological, physical and sexual abuse	**LAC:** • **BRA**: 9.3% of women suffered verbal abuse[164]. • **COL**: 42% of women were not allowed to move freely during labor, and only 5.1% of women who gave birth vaginally were allowed to choose their birthing positions. 55% of women who received c-sections were immobilized.[165] • **MEX**: In Pueblas and Chiapas, verbal abuse was the most common form of obstetric violence (39.4% of reported disrespect and abuse events), followed by physical abuse (32%).[166] **AFRICA:** • **KEN**: 26.7% of adolescent mothers in Nairobi experienced verbal abuse during childbirth, and 17% of the girls reported detainment.[167] • **MWI:** 83% of women were encouraged not to bring a support person to the delivery room, and 94% of women were not asked about their preferred birthing position.[168] • **UGA:** A 2016 study found that 29.3% of women experienced verbal abuse during childbirth.[169] **ASIA:** • **IND:** A 2020 meta-analysis found that verbal abuse was the second most prevalent form of disrespect and abuse (26%) followed by threats (26%) and physical abuse (17%).[170] • **BGD:** Non-dignified care (40%) and physical abuse (14%) were the most common forms of disrespect and abuse. Non-dignified care included lack of birth companion and abusive language.[171] • **PAK:** A 2021 study found that most women experienced a lack of supportive care (99.7%) and a loss of autonomy (97.5%) during facility-based childbirth. The prevalence of physical or verbal abuse was 15%.[172] Similarly, a 2022 study reported 75% of women birthed alone, 54% of women experienced verbal abuse, and 18% of women reported physical abuse.[173] **EUROPE:** • **ROU:** 76% of women who gave birth vaginally in a public hospital reported that a certain birth position was forced on them, and 84% of women were not allowed to have a support person present during labor (compared to 50% and 32% in private settings, respectively).[174] **UNITED STATES:** • **USA**: 1.3% of women reported physical abuse and 8.5% of women reported being shouted at.[175]

164 Sample size: 4,000. *In* Marilia Arndt Mesenburg et al., *Disrespect and abuse of women during the process of childbirth in the 2015 Pelotas birth cohort,* 15 BMC Reproductive Health 54 (2018), https://doi.org/10.1186/s12978-018-0495-6.

165 Sample size: 2,943. *In Primera Encuesta Nacional de Parto y Nacimiento,* Movimiento Nacional por la salud sexual y reproductive en Colombia (2024), https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.

166 Sample size: 867. *In* Alexander Brenes Monge et al., *Disrespect and Abuse in Obstetric Care in Mexico: An Observational Study of Deliveries in Four Hospitals,* 25 Mat. Child Health J. 565 (2021), https://doi.org/10.1007/s10995-020-03052-9.

167 Sample size: 491. *In* Anthony Idowu Ajayi et al., *Adolescents' experience of mistreatment and abuse during childbirth: a cross-sectional community survey in a low-income informal settlement in Nairobi, Kenya,* 8 BMJ Glob. Health 11 (2023), https://doi.org/10.1136/bmjgh-2023-013268.

168 Sample size: 2,100. *In* Reena Sethi et al., *The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery,* 14 Reprod. Health 111 (2017), https://doi.org/10.1186/s12978-017-0370-x.

169 Sample size: 374. *In* Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda,* 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.

170 Explored the findings of 7 articles. *In* H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis,* 66 J. Postgrad Med. 133 (2020), https://doi.org/10.4103/jpgm.JPGM_648_19.

171 Sample size: 891. *In* Neha Madhiwalla et al., *Identifying disrespect and abuse in organisational culture: a study of two hospitals in Mumbai, India,* 26 Reprod. Health Matters 36 (2018), https://doi.org/10.1080/09688080.2018.1502021.

172 Sample size: 783. *In* Waqas Hameed, Mudassir Uddin, & Bilal Iqbal Avan, *Are underprivileged and less empowered women deprived of respectful maternity care: Inequities in childbirth experiences in public health facilities in Pakistan,* 16 PLoS One (2021), https://doi.org/10.1371/journal.pone.0249874.

173 Sample size: 200. *In* Sughra Abbasi et al., *Women's Experience with Obstetric Violence during Hospital Birth,* 16 Pakistan J. Med. Health Sci. 506 (2022), https://doi.org/10.53350/pjmhs22163506

174 Sample size: 5,623. *In* Diana-Elena Neaga, Laura Grünberg, Crina Radu, *Childbirth Experience in Romanian Hospitals: Research Report on Obstetric Violence,* Independent Midwives Association (2024), https://moasele.ro/wp-content/uploads/2024/11/Report-on-Obstetric-Violence_AMI_November_2024.pdf.

175 Sample size: 2,138. *In* Saraswathi Vedam et al., *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States,* 16 Reprod. Health 77 (2019), https://doi.org/10.1186/s12978-019-0729-2.

Form of mistreatment	Prevalence
Stigma and discrimination	**LAC:** • **COL**: Over 70% of women who gave birth vaginally reported that their cultural practices were not respected during childbirth.[176] • **MEX**: In Pueblas and Chiapas, discrimination accounted for 28.6% of reported cases of obstetric violence.[177] **AFRICA:** • **KEN**: 15.1% of adolescent mothers in Nairobi experienced stigma & discrimination during childbirth.[178] • **Asia**: • **IND:** A 2020 meta-analysis found that discrimination occurred in 15% of deliveries.[179]
Forced medical act or medical act performed without consent or against expressed refusal	**LAC:** • **BRA**: 5.8% of women had invasive and/or inappropriate procedures without an explanation of why it was being conducted.[180] • **COL**: In ~38% of deliveries, episiotomies or other interventions were performed without the consent of the pregnant women.[181] 33% of c-sections were non-consensual. • **MEX**: A 2021 study found 20.2% of births involved nonconsensual medical interventions.[182] A 2024 study reported that 23.2% of women received a forced contraceptive method or sterilization without knowledge of authorization, and 8.6% of women were forced or threatened to sign paperwork.[183] Of the women who underwent c-section, 37.3% of women were not informed about the need of a c-section, and 34.5% did not provide authorization for their c-section.[184] In Pueblas and Chiapas, 76% of women subjected to genital cleansing did not consent to the procedure. Similarly, 62.6% of women subjected to genital shaving did not consent to the procedures.[185] **AFRICA:** • **KEN**: A 2015 study found the prevalence of nonconsensual care to be low (4.3%).[186] • **MWI:** In 2017, the prevalence of non-consented episiotomies was 0.5%.[187] However, a 2022 study found that there was a lack of consent and engagement in the decision-making process in 40% of births.[188] Similarly, a 2020 study found that only 31% of women expressed that they had received information on the risks of the c-section before the surgery.[189] • **UGA:** A 2016 study found the prevalence of non-consensual treatment to be 13.8%.[190]

176 Sample size: 2,943. *In Primera Encuesta Nacional de Parto y Nacimiento,* Movimiento Nacional por la salud sexual y reproductive en Colombia (2024), https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.

177 Sample size: 867. *In* Alexander Brenes Monge et al., *Disrespect and Abuse in Obstetric Care in Mexico: An Observational Study of Deliveries in Four Hospitals,* 25 Mat. Child Health J. 565 (2021), https://doi.org/10.1007/s10995-020-03052-9.

178 Sample size: 491. *In* Anthony Idowu Ajayi et al., *Adolescents' experience of mistreatment and abuse during childbirth: a cross-sectional community survey in a low-income informal settlement in Nairobi, Kenya,* 8 BMJ Glob. Health 11 (2023), https://doi.org/10.1136/bmjgh-2023-013268.

179 Explored the findings of 7 articles. *In* H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis,* 66 J. Postgrad Med. 133 (2020), https://doi.org/10.4103/jpgm.JPGM_648_19.

180 Sample size: 4,000. *In* Marilia Arndt Mesenburg et al., *Disrespect and abuse of women during the process of childbirth in the 2015 Pelotas birth cohort,* 15 BMC Reproductive Health 54 (2018), https://doi.org/10.1186/s12978-018-0495-6.

181 Sample size: 2,943. *In Primera Encuesta Nacional de Parto y Nacimiento,* Movimiento Nacional por la salud sexual y reproductive en Colombia (2024), https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.

182 Sample size: 3,535. *In Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH),* Instituto Nacional de Estadística y geografía (INEGI) (2021), https://www.inegi.org.mx/programas/endireh/2021/#documentacion

183 Sample size: 19,322. *In* Marian Marian et al., *Prevalence of different variations of non-consented care during the childbirth process in Mexico by geographical regions: comparing ENDIREH survey data from 2016 to 2021*, 24 BMC Pregnancy Childbirth (2024), https://doi.org/10.1186/s12884-024-06549-1.

184 Sample size: 19,322. *In* Marian Marian et al., *Prevalence of different variations of non-consented care during the childbirth process in Mexico by geographical regions: comparing ENDIREH survey data from 2016 to 2021*, 24 BMC Pregnancy Childbirth (2024), https://doi.org/10.1186/s12884-024-06549-1.

185 Sample size: 867. *In* Alexander Brenes Monge et al., *Disrespect and Abuse in Obstetric Care in Mexico: An Observational Study of Deliveries in Four Hospitals,* 25 Mat. Child Health J. 565 (2021), https://doi.org/10.1007/s10995-020-03052-9.

186 Sample size: 641. *In* Timothy Abuya et al., *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya,* 10 PLoS One 4 (2015), https://doi.org/10.1371/journal.pone.0123606

187 Sample size: 2,100. *In* Reena Sethi et al., *The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery,* 14 Reprod. Health 111 (2017), https://doi.org/10.1186/s12978-017-0370-x.

188 Sample size: 374. *In* Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda,* 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.

189 Sample size: 160. *In* Siem Zethof et al., *Pre-post implementation survey of a multicomponent intervention to improve informed consent for caesarean section in Southern Malawi,* 10 BMJ Open (2020), https://doi.org/10.1136/bmjopen-2019-030665.

190 Sample size: 374. *In* Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda,* 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.

Form of mistreatment	Prevalence
Forced medical act or medical act performed without consent or against expressed refusal ***(continued)***	**ASIA:** • **BGD**: A 2024 study found that 13% of women reported non-consented care. This included language barriers, lack of consent, examinations and procedures being conducted without explanation, lack of choice in birth position, and lack of encouragement to ask questions.[191] • **IND**: A 2020 meta-analysis found that non-consensual treatment was the most prevalent form of disrespect and abuse (50%).[192] A small 2020 study in Chennai, India found that although most patients that had undergone a C-section were informed on the indications, risks, and benefits of the surgery, 76.3% were not adequately informed on alternative procedures, 98.9% were not adequately informed on the necessity of anesthesia, and 100% were not adequately informed on their right to refuse the procedure.[193] • **PAK:** According to two studies published in 2018, the most common types of mistreatment was non-consented care, which was reported by 81% and 97.5% of women respectively. This included performing a procedure without consent, failing to adequately explain a procedure, lack of birthing options, and coercion to undergo a c-section.[194] More recently, a 2022 study found that 36% of women experienced non-consented care and 40% experienced unconsented vaginal examinations. In addition, when women were asked about the exam that they were undergoing, only 60% reported that their midwife had asked for permission before beginning, and only 53% understood why the exam was needed.[195] **EUROPE:** • **ESP**: 83% of women experienced non-consensual care, but only 38% of women having perceived themselves as having experienced obstetric violence. Reported types of nonconsensual care included: uninformed episiotomy, lack of information about procedures to be performed, and lack of consenting process.[196] • **ROU:** Abusive examinations and non-consensual procedures were the most prevalent forms of obstetric violence. 87% of women who had vaginal deliveries and 83-90% of women who had c-section births reported non-consensual procedures.[197] **UNITED STATES:** • **USA:** 4.5% of women reporting force or coercion into accepting a procedure or treatment and 1.2% of women reported that their information was non-consensually shared.[198]

191 Sample size: 891. Md Nuruzzaman Khan, Shimlin Jahan Khanam & M. Mofizul Islam, *Disrespect and Abuse Experienced by Mothers While Accessing Delivery Healthcare Services in Bangladesh* (2024) (preprint research article), https://doi.org/10.21203/rs.3.rs-4439968/v1.

192 Explored the findings of 7 articles. *In* H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis,* 66 J. Postgrad Med. 133 (2020), https://doi.org/10.4103/jpgm.JPGM_648_19.

193 Sample size: 93, in Chennai, India in 2020. *In* Saswati Tripathy et al., *Informed consent process before caesarean section: A study of patient's perspective regarding adequacy of consent process,* 7 Indian J. Obstet. Gynecol. Research 239 (2020), http://dx.doi.org/10.18231/j.ijogr.2020.049.

194 Sample size: 1,334. *In* Waqas Hameed & Bilil Iqbal Avan, *Women's experiences of mistreatment during childbirth: A comparative view of home and facility-based births in Pakistan,* 13 PLoS One 3 (2018), https://doi.org/10.1371/journal.pone.0194601; Sample size: 360 *in* 2016. In Zainab Azhar, Oyinlola Oyebode & Haleema Masud, *Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care,* 13 PLoS One (2018), https://doi.org/10.1371/journal.pone.0200318.

195 Sample size: 200. *In* Sughra Abbasi et al., *Women's Experience with Obstetric Violence during Hospital Birth,* 16 Pakistan J. Med. Health Sci. 506 (2022), https://doi.org/10.53350/pjmhs22163506

196 Sample size: 17,541. *In* Desirée Mena-Tudela et al., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences,* 17 Int. J. Environ. Res. Public Health 7726 (2020), https://doi.org/10.3390/ijerph17217726.

197 Sample size: 5,623. *In* Diana-Elena Neaga, Laura Grünberg, Crina Radu, *Childbirth Experience in Romanian Hospitals: Research Report on Obstetric Violence,* Independent Midwives Association (2024), https://moasele.ro/wp-content/uploads/2024/11/Report-on-Obstetric-Violence_AMI_November_2024.pdf.

198 Sample size: 2,138. *In* Saraswathi Vedam et al., *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States,* 16 Reprod. Health 77 (2019), https://doi.org/10.1186/s12978-019-0729-2.

Form of mistreatment	Prevalence
Non-medically necessary (harmful) procedures	**LAC:** • **BRA**: The CS rate is 55.7%. [199] The episiotomy rate for vaginal births was 19.4% in 2019.[200] • **COL**: The CS rate is 44.6%.[i] [201] The episiotomy rate is 50.9%, and that 74% of episiotomies were performed non-consensually. Alarmingly, this study also revealed that the prevalence of an episiotomy suture with extra stitches was 44.2%, and only 10.4% of women explicitly consented to this procedure.[202] • **MEX**: In Pueblas and Chiapas, 82.4% of women were subjected to genital cleansing and 13% of women were subjected to genital shaving.[203] The CS rate is 45.5%.[i] [204] **AFRICA:** • **UGA**: A 2019 study found that the prevalence of episiotomies was 73%.[205] **ASIA:** • **BGD**: The CS rate is 45%[i] nationally, and as high as 81% in private hospitals.[206] Studies have reported routine episiotomy rates of 65%[207] and 81.4%.[208] • **IND:** The CS rate is 21.5%[i] nationally. There is a stark divide between the CS rate of public (14.3%) and private (47.4%) facilities.[209] In 2016, the episiotomy rate was estimated to be 63.4% and primiparous women were 8.8 times more likely to undergo an episiotomy than multiparous women.[210] • **PAK:** 30% of women had their abdomen pressed painfully during delivery.[211] The CS rate is 18.4%.[i] [212] **EUROPE:** • **ESP:** The CS rate is 27.3%[i] [213] • **ROU**: Romania has the highest CS rate in Europe, calculated to be 46.9%.[i] [214] In 2018, the episiotomy rate was estimated to be 71.4% overall, and 92.7% in primiparous women.[215]

199 Sample size: 3,017,668. *In* Gilberto Magalhães Occhi et al., *Strategic measures to reduce the caesarean section rate in Brazil,* 392 The Lancet 1290 (2018), https://doi.org/10.1016/S0140-6736(18)32407-3; Ana Pilar Betran et al., *Trends and projections of caesarean section rates: global and regional estimates,* 6 BMJ Glob Health e005671 (2021), https://doi.org/10.1136/bmjgh-2021-005671.

200 Juraci A. Cesar et al., *Episiotomy in Southern Brazil: prevalence, trend, and associated factors,* 56 Rev Saude Publica 26 (2022), https://doi.org/10.11606/s1518-8787.2022056003908.

201 Sample size: 1,965,224. *In* John Jairo Zuleta-Tobón, *Evolución de la cesárea en Colombia y su asociación con la naturaleza jurídica de la institución donde se atiende el parto,* 74 Rev Colomb Obstet Ginecol 3901 (2023), https://doi.org/10.18597/rcog.3901.

202 Sample size: 2,943. *In* Movimiento Nacional por la salud sexual y reproductive en Colombia, *Primera Encuesta Nacional de Parto y Nacimiento* (2024), https://www.movimientossr.com/proyectos/decidirgestarparir-a48er.

Rodrigo Garcia-Cerde et al., *Health care workers' perceptions of episiotomy in the era of respectful maternity care: a qualitative study of an obstetric training program in Mexico,* 21 BMC Preg Childbirth 549 (2021), https://doi.org/10.1186/s12884-021-04022-x.

203 Sample size: 867. *In* Alexander Brenes Monge et al., *Disrespect and Abuse in Obstetric Care in Mexico: An Observational Study of Deliveries in Four Hospitals,* 25 Mat. Child Health J. 565 (2021), https://doi.org/10.1007/s10995-020-03052-9.

204 Sample size: 2,064,507. *In* Tarsicio Uribe-Leitz et al., *Trends of caesarean delivery from 2008 to 2017, Mexico,* 97 Bull World Health Organ 502 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6593338/.

205 Sample size: 249. *In* Francis Pebalo Pebolo et al., *Prevalence and factors associated with episiotomy practice among primiparous women in Mulago national referral hospital Uganda,* 5 Int J Preg Childbirth 197 (2019), http://dx.doi.org/10.15406/ipcb.2019.05.00176.

206 Aimee Hairon et al., *"I can't make it safe, so I don't do it": Exploring obstetricians' views on barriers and enablers to promoting vaginal birth after caesarean section in Bangladesh,* 4 PLoS Glob Pub Health e0003963 (2024), https://doi.org/10.1371/journal.pgph.0003963.

207 Sample size: 50. *In* Shahana Parvin et al., *Fetomaternal outcome of vaginal birth after previous cesarean section (VBAC): study on tertiary level hospital in Bangladesh,* 4 Sch Int J Obstet Gynec 440 (2021), https://saudijournals.com/media/articles/SIJOG_411_440-451_Nw1uQfp.pdf.

208 Sample size: 100. *In* Mohammed Ali Chowdhury et al., *Evaluate and outcome safety of epidural analgesia in surgical practice for labour pain: study on tertiary hospital in Bangladesh,* 9 Sch J App Med Sci 1574 (2021), https://saspublishers.com/media/articles/SJAMS_910_1574-1580.pdf.

209 Sample size: 1,462,653. *In* Ministry of Health & Family Welfare (Government of India), *National Family Health Survey (NFHS-5) 2019-21* (2021), https://mohfw.gov.in/sites/default/files/NFHS-5_Phase-II_0.pdf.

210 Sample size: 177,252. *In* Shalini Singh et al., *Pattern of episiotomy use & its immediate complications among vaginal deliveries in 18 tertiary care hospitals in India,* 143 Indian J Med Res 474 (2016), https://doi.org/10.4103/0971-5916.184304.

211 Sample size: 200. *In* Sughra Abbasi et al., *Women's Experience with Obstetric Violence during Hospital Birth,* 16 Pakistan J. Med. Health Sci. 506 (2022), https://doi.org/10.53350/pjmhs22163506.

212 WHO, *Births by caesarean section (%),* https://www.who.int/data/gho/data/indicators/indicator-details/GHO/births-by-caesarean-section-(-) (accessed Jan. 24, 2025).

213 WHO, *Births by caesarean section (%),* https://www.who.int/data/gho/data/indicators/indicator-details/GHO/births-by-caesarean-section-(-) (accessed Jan. 24, 2025).

214 Angela Marian-Pavlenco et al., *Cesarean delivery in a tertiary institution of the Republic of Moldova: analysis using the Robson classification,* 4 AJOG Glob Reports 100408 (2024), https://doi.org/10.1016/j.xagr.2024.100408.

215 Sample size: 11,863. *In* Andrada Pasc et al., *A multicenter cross-sectional study of episiotomy practice in Romania,* 25 J Eval Clin Pract 206 (2018), https://doi.org/10.1111/jep.13062; Béatrice Blondel et al., *Variations in rates of severe perineal tears and episiotomies in 20 European countries: a study based on routine national data in Euro-Peristat Project,* 95 Acta Obstetricia et Gynecologica Scandinavica 746 (2016), https://doi.org/10.1111/aogs.12894.

Form of mistreatment	Prevalence
Non-medically necessary (harmful) procedures *(continued)*	**UNITED STATES:** • **USA**: A 2024 systematic review found that multiple types of non-consensual acts were reported across the USA-focused literature including, nonconsensual clamping of the cord, rupture of the membranes before birth, continuous fetal monitoring, injections, episiotomy, vaginal exams, and medical students in the room.[216] A 2024 study found that 21% of women in California had an episiotomy during childbirth, and 75% of women who underwent an episiotomy reported "not having a choice in receiving it".[217] • **USA**: The national CS rate is 32%[i] [218] The average national rate of episiotomies was 4.6%.[219]
Refusal or delay of care	**LAC:** • **BRA**: 5.9% of women experienced denial of care.[220] **AFRICA:** • **KEN**: 14.3% of women experience neglect or abandonment during childbirth.[221] • **MWI:** 56% of women were denied pain medications.[222] • **UGA:** 31.9% of women experienced patient neglect during childbirth.[223] **UNITED STATES:** • **USA:** 10% of women reported being ignored or refused help from their provider.[224]
Poor communication between pregnant individual and providers	**LAC:** • **MEX**: 56.2% of women reported pressure to get a contraceptive method or sterilization after giving birth.[225] **ASIA:** • **BGD**: 35% of women reported that they were concerned that their providers were not doing enough for them and 30% stated that they were not able to express their concerns about the care they received. Similarly, women received insufficient information throughout their birthing process: only 50% were told about the findings of their initial examinations, and in less than 1% of cases were delivery plans confirmed during labor monitoring.[226] • **PAK:** According to a 2021 study, 100% of women experienced ineffective communication.[227]

LEGEND:
BRA: Brazil; **COL**: Colombia, **MEX**: Mexico; **KEN**: Kenya; **UGA**: Uganda; **MWI**: Malawi; **IND**: India; **BGD**: Bangladesh; **PAK**: Pakistan; **ESP**: Spain; **ROU**: Romania; **USA**: United States of America

216 Sample size: 65,343. *In* Laura Katrina Fraser et al., *Prevalence of obstetric violence in high-income countries: A systematic review of mixed studies and meta-analysis of quantitative studies,* 104 Acta Obstetricia et Gynecologica Scandinavica 13 (2024), https://doi.org/10.1111/aogs.14962.

217 Sample size: 295,000. *In* Mounika Polavarapu et al., *Role of Obstetric Violence and Patient Choice: Factors Associated With Episiotomy,* 69 J. Midwifery Women's Health 718, https://doi.org/10.1111/jmwh.13655.

218 WHO, *Births by caesarean section (%),* https://www.who.int/data/gho/data/indicators/indicator-details/GHO/births-by-caesarean-section-(-) (accessed Jan. 24, 2025).

219 Sample size: 2,300 hospitals. *In* The Leapfrog Group, *State of maternity care in the U.S.: The Leapfrog Group 2023 report on trends in c-sections, early elective deliveries,* and episiotomies (2023), https://www.leapfroggroup.org/sites/default/files/Files/2023%20Maternity%20Report_Final_0.pdf.

220 Sample size: 4,000. *In* Marilia Arndt Mesenburg et al., *Disrespect and abuse of women during the process of childbirth in the 2015 Pelotas birth cohort,* 15 BMC Reproductive Health 54 (2018), https://doi.org/10.1186/s12978-018-0495-6.

221 Sample size: 641. *In* Timothy Abuya et al., *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya,* 10 PLoS One 4 (2015), https://doi.org/10.1371/journal.pone.0123606

222 Sample size: 2,100. *In* Reena Sethi et al., *The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery,* 14 Reprod. Health 111 (2017), https://doi.org/10.1186/s12978-017-0370-x.

223 Sample size: 374. *In* Kasule Aaron and Jerome K. Kabakyenga, *Terror and tears in the labour suit: the prevalence and forms of patient abuse by health workers during childbirth in Uganda,* 4 Texila J. of Pub. Health 2 (2016), https://www.texilajournal.com/public-health/article/444-terror-and-tears.

224 Sample size: 2,403. *In* Yousra A. Mohamoud et al., *Vital Signs: Maternity Care Experiences — United States, April 2023,* 72 MMWR Morb. Mortal. Wkly Rep. 961 (2023), http://dx.doi.org/10.15585/mmwr.mm7235e1.

225 Sample size: 19,322. *In* Marian Marian et al., *Prevalence of different variations of non-consented care during the childbirth process in Mexico by geographical regions: comparing ENDIREH survey data from 2016 to 2021*, 24 BMC Pregnancy Childbirth (2024), https://doi.org/10.1186/s12884-024-06549-1.

226 Sample size: 295 women and 158 providers. *In* Alexander Manu et al., *Respectful maternity care delivered within health facilities in Bangladesh, Ghana and Tanzania: a cross-sectional assessment preceding a quality improvement intervention,* 11 BMJ Open (2021), https://doi.org/10.1136/bmjopen-2020-039616.

227 Sample size: 783. *In* Waqas Hameed, Mudassir Uddin, & Bilal Iqbal Avan, *Are underprivileged and less empowered women deprived of respectful maternity care: Inequities in childbirth experiences in public health facilities in Pakistan,* 16 PLoS One (2021), https://doi.org/10.1371/journal.pone.0249874.

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